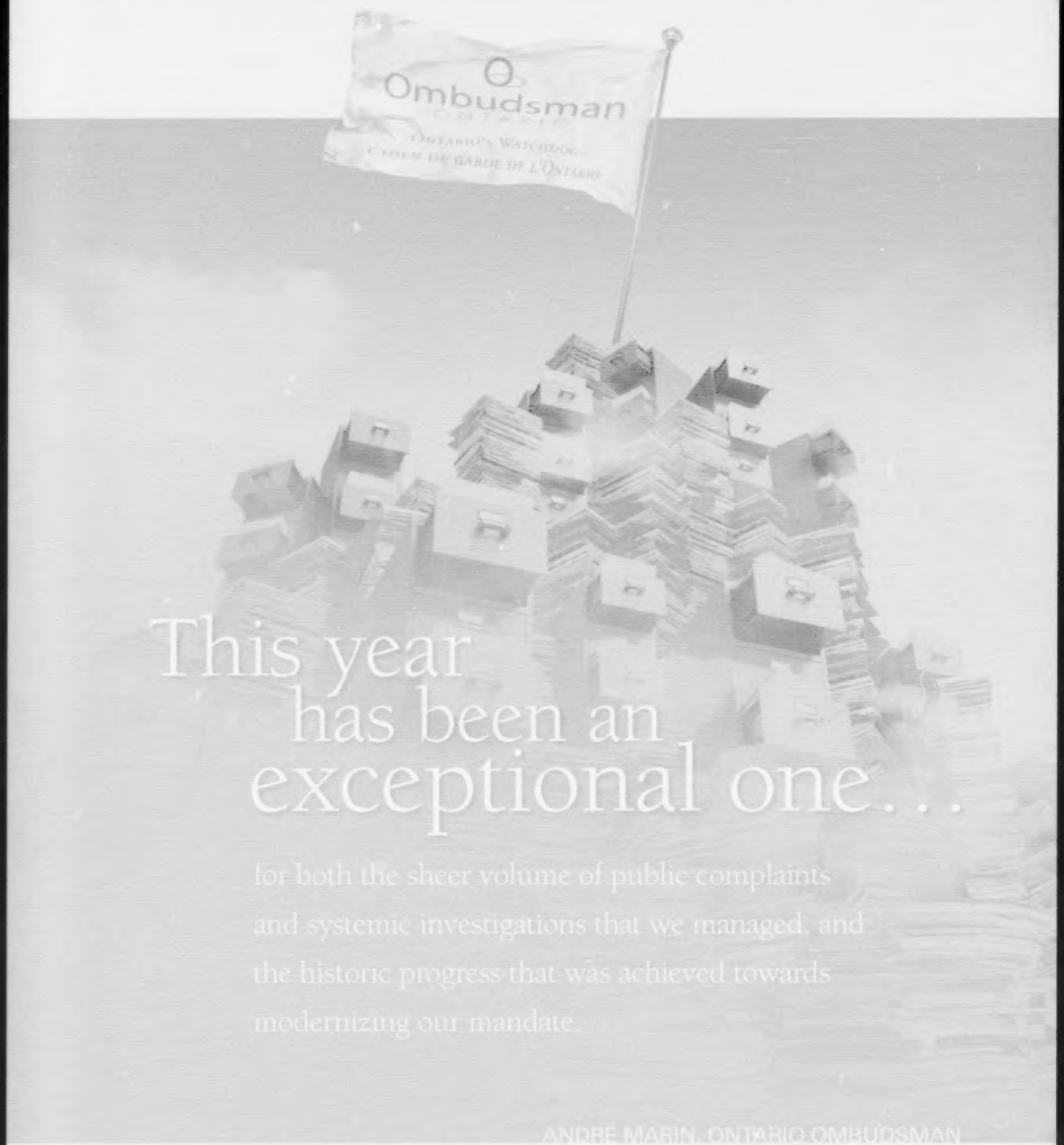
Ombudsman
ONTARIO

ONTARIO'S WATCHDOG

ANNUAL REPORT

2013 – 2014



This year has been an exceptional one...

for both the sheer volume of public complaints and systemic investigations that we managed, and the historic progress that was achieved towards modernizing our mandate.

ANDRE MARIN, ONTARIO OMBUDSMAN

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Ombudsman's Message

Reaching New Heights

Photo by Brian Walker

This year has been an exceptional one for my Office, for both the sheer volume of public complaints and systemic investigations that we managed, and the historic progress that was achieved towards modernizing our mandate.

In **2013-2014**, we worked tirelessly to address a precedent-setting **26,999** cases, an increase of some 37% over the previous year. We resolved tens of thousands of individual concerns expeditiously through shuttle diplomacy, focused and thorough fact-gathering, and escalating inquiries up the bureaucratic chain of command. We met with high-level officials to engage in proactive troubleshooting, preventing disturbing complaint trends from evolving into crisis. At the same time, our Special Ombudsman Response Team tackled a record number of active investigations, focused on systemic problems affecting thousands of Ontarians.

And for the first time since this Office was established in 1975, the Government of Ontario took concrete action to address the decades-old accountability gap that prevents us – unlike any other provincial ombudsman in Canada – from investigating the broader public sector. Bill 179, the *Public Sector and MPP Accountability and Transparency Act, 2014*, proposed expansion of our jurisdiction to municipalities, universities and school boards – a move that would finally allow Ontarians to complain to us about those bodies.

Although the progress of the bill was halted by the dissolution of the Legislative Assembly on May 2, 2014 for the spring 2014 election, this was a significant first step towards bringing much-needed independent scrutiny to the so-called "MUSH sector" (municipalities, universities, school boards, hospitals and long-term care facilities, children's aid societies and police).

The Human Equation

My Office is often the last hope for those who have come up against an impenetrable wall of bureaucratic indifference. We work hard to sensitize government officials to human suffering, break down the barriers erected by "rulitis" – a slavish devotion to the rules to the exclusion of good judgment – and construct common-sense solutions. This report is filled with examples of cases where we assisted to humanize government, often for the most vulnerable members of our society.

For example, when the mother of a nine-year-old girl with severe autism called us, frantic because her daughter was being discharged from a psychiatric ward without proper supports in place, we facilitated a resolution. We were able to persuade the **Ministry of Children and Youth Services** to intervene, and, as a result, the child's hospital stay was extended until residential treatment could be arranged.

When inadequate supports at a group home left a 63-year-old woman who has developmental disabilities spending weekends in the care of her aging and blind mother – and at one point, at a police station in handcuffs – we successfully urged the **Ministry of Community and Social Services** to fund necessary supportive care and supervision for her. Working with the same Ministry, we helped obtain proper placements for two young men with autism whose explosive behaviour threatened the safety of their families – thereby breaking a cruel cycle of repeated police interventions and hospitalizations.

Then there was the single mother who was struggling to support her teenage son who has developmental disabilities while **$14,000** sat for years in her name in a **Family Responsibility Office (FRO)** bank account. We were able to break through the paperwork logjam and ensure her delayed child support payments were finally released.

We also helped a man who had run into roadblocks for years trying to obtain **Ontario Health Insurance Plan** coverage because **ServiceOntario** officials didn't recognize his Canadian military birth certificate. His situation became critical after several catastrophic health problems landed him in hospital with a bill for more than **$100,000**. After we cut through the red tape, he received **OHIP** coverage and his hospital debt was wiped out.

An Ounce of Prevention

In **2013-2014**, we confronted brewing problematic issues in many areas. After a 28-year-old man with autism drowned in a bathtub at a group home, we assisted his parents in their quest to stop such tragedies recurring in future. As a result of our discussions with the **Office of the Chief Coroner**, additional review was undertaken and a recommendation was issued to minimize the risk of similar deaths.

Our regular review of **FRO** cases and trends uncovered a myriad of enforcement delays and mistakes, as well as a monumental miscommunication between the **FRO** and the **Ontario Disability Support Program (ODSP)** affecting hundreds of families.

Typically, if someone receiving social assistance such as ODSP is also entitled to support payments collected from an ex-spouse by the FRO, the support money is "assigned" to ODSP for as long as the person is an ODSP client. "However, we learned that for years, the FRO had continued to divert hundreds of thousands of dollars in child and spousal support payments to the ODSP - for families whose support "assignments" had long since expired. The ODSP had neglected to cancel the assignments, and the money sat in an account. In one mother's case, **$8,000** piled up over 14 years. We met with senior officials of both agencies to monitor their plans to resolve this colossal confusion and pay the recipients the money they are owed.

We also closely monitored the **Ministry of Health and Long-Term Care's** administration of its program for exceptional access to drugs. In one instance, we helped the family of a 14-year-old boy who has multiple disabilities gain access to a drug he desperately needed but could not afford. Our involvement spurred the Ministry to re-examine its criteria for funding the drug, clearing the way for others facing similar challenges. We also prodded the Ministry to educate hospitals about the law prohibiting denial of service based on residence, after an elderly stroke victim was improperly denied rehabilitation services by three hospitals because of where he lived.

In addition, we worked behind the scenes to alert **Ministry of Community Safety and Correctional Services** officials to emerging issues in correctional facilities. Our efforts resulted in a policy review relating to internal investigations of serious inmate-on-inmate assaults, closer monitoring of inmates in segregation, and improved responses to inmate concerns about medical treatment.

SORTing Out Systemic Issues

Our high-profile systemic investigations continue to spark constructive government action. Our latest report, ***Better Safe Than Sorry*** (April 2014), focused on the **Ministry of Transportation's** monitoring of drivers with uncontrolled hypoglycemia. The Ministry accepted my **19** recommendations and is working on improving its system for reporting and monitoring drivers whose medical conditions might pose safety risks.

The **Ministry of Community Safety and Correctional Services** has also been working diligently to implement the 45 recommendations set out in my June 2013 report, ***The Code***, concerning the Ministry's response to allegations of excessive use of force against inmates. Similarly, the **Ontario Provincial Police** and the **Ministry of Community Safety and Correctional Services** have continued to address the 34 recommendations from my report, ***In the Line of Duty*** (October 2012), and are making strides to raise awareness of and minimize risks associated with operational stress injuries in policing.

As of the writing of this report, we have an unprecedented four large-scale field investigations underway, three of which I announced in 2013-2014. We continue to evaluate and analyze the complex and substantial evidence obtained in our investigation into the services provided by the **Ministry of Community and Social Services** for adults with developmental disabilities who are in crisis situations – an investigation that has drawn more than 1,100 complaints.

We are finishing up our investigation of the **Ministry of Education's** response to complaints and concerns about unlicensed daycare operators, commenced in July 2013 after the death of two-year-old Eva Ravikovich in an illegal home daycare in Vaughan. In addition, our investigation into the direction provided by the **Ministry of Community Safety and Correctional Services** to police for de-escalating conflict situations is progressing well. I launched this investigation in August 2013, after 18-year-old Sammy Yatim was shot by police while wielding a knife, alone on a Toronto streetcar. I am pleased to be working on this case with two expert police advisors, another first for our Office.

Finally, we are in the midst of our largest investigation yet, into **Hydro One's** billing practices and customer service, which has generated more than **7,800** complaints as of the writing of this report. As this systemic investigation progresses, we have already seen the agency accept blame for problems and begin to fix existing system failures. As with all systemic investigations, our **SORT** and **Operations** teams have worked in tandem to address urgent individual cases and identify systemic issues for follow-up. In the **Case Summaries** section of this report, we have included some of the more egregious individual Hydro One cases we have encountered so far, such as that of the retiree who received a whopping bill for **$12,116** after no one checked his hydro meter for two years, and the woman who was shocked when Hydro One removed **$8,390** from her bank account without warning because it deemed her past 22 estimated bills too low. After our Office intervened, Hydro One acknowledged its errors in both cases.

> Many of those who have contacted us are in vulnerable situations and say they have faced significant financial hardship and stress because of their dealings with Hydro One. And when customers try to get answers from Hydro One, they are stymied, just as my Office has often been stymied when we intervened.
>
> Sometimes it's like wrestling with a slippery pig – and that's why my heart goes out to those average citizens who try to take on the Goliath that is Hydro One."

Ombudsman André Marin, at press conference announcing investigation, February 4, 2014

Unfinished Business – Dying to be Law

Our work does not conclude when a government organization agrees to implement our suggested solutions. We actively monitor and seek updates as implementation of our recommendations progresses. Regrettably, progress on some government commitments has stalled in the past year, especially in the area of legislative reform.

For example, there is still no bill anywhere in sight to strengthen the mandate of the **Special Investigations Unit (SIU)**, and clarify police obligations to co-operate with the SIU's criminal investigations of serious injuries and deaths arising from police interaction. I first called for a stronger legislative framework for the SIU in my report ***Oversight Unseen*** (September 2008), and focused on the need for the **Ministry of the Attorney General** to support the SIU in my follow-up report, ***Oversight Undermined*** (December 2011). I will continue to seek improvements to the system for civilian oversight of police, which I believe are necessary to reinforce public confidence in policing.

Another legislative change that is missing in action is the replacement for the antiquated, World War II-era *Public Works Protection Act (PWPA)*, which I recommended in my report ***Caught in the Act*** (December 2010). The *PWPA* featured prominently in the massive civil rights abuses during the G20 summit in Toronto four years ago, and the government has twice introduced bills to replace it – only to have them die on the order paper (most recently on May 2, 2014). Given its checkered history, it is disturbing that the *PWPA* is still on the books, particularly when one considers that Ontario is in the midst of preparations for hosting the Pan Am and Parapan Am Games in Toronto in 2015.

Several other bills that would have addressed my recommendations were also casualties of the May 2, 2014 dissolution of the Legislature for this spring's election. Bill 151, the *Strengthening and Improving Government Act, 2014* proposed amendments to the *Highway Traffic Act* to establish regulatory standards for stretcher transportation services. This related to a commitment that my Office obtained in 2011 from the **Ministries of Health and Long-Term Care** and **Transportation** to improve the health and safety standards for private companies transferring non-emergency patients. And Bill 173, the *Highway Traffic Amendment Act (Keeping Ontario's Roads Safe), 2014*, included amendments relating to recommendations from my report ***Better Safe Than Sorry*** (April 2014). I am hopeful that the next government will recognize the importance of reintroducing these measures, and will follow up on them.

Making MUSH History

For the past nine years, I have vigorously advocated for modernization of my Office's mandate to include the **MUSH** sector – **m**unicipalities, **u**niversities, **s**chool boards, **h**ospitals and long-term care homes, children's aid societies and police. Combined, these organizations receive more than **$50 billion** in provincial funding each year, and have a significant impact on the lives of Ontario's citizens, literally from birth to death. Yet they are not subject to the same robust scrutiny that applies to provincial bodies within my jurisdiction – which include all ministries, agencies, boards, commissions, corporations and tribunals.

My predecessors, starting with the first Ombudsman, Arthur Maloney (1975-1979), all called for expansion of the Ombudsman's authority to various **MUSH** bodies. Since 2005, momentum for change has progressively gained traction. More than **130** petitions, signed by thousands of Ontarians, have been tabled in the Legislature to this effect, and MPPs have introduced **18** private member's bills seeking changes to my jurisdiction to include **MUSH** bodies. And in recent years, both Premier Kathleen Wynne and her predecessor Dalton McGuinty, along with other provincial leaders, have assured me that they supported renovation of my mandate in principle.

But this year marked the first time in nearly 40 years that the government of Ontario has actually put pen to paper to extend Ombudsman oversight. On March 6, 2014, Premier Wynne made the historic announcement that the government would table legislation aimed at strengthening accountability and increasing transparency, including extending the Ontario Ombudsman's oversight to **m**unicipalities, publicly funded **u**niversities and **s**chool boards. This was followed on March 24, 2014, by introduction of Bill 179, the ***Public Sector and MPP Accountability and Transparency Act, 2014***.

In addition to expanding the authority of my Office over the **M**, **U** and **S** in **MUSH**, Bill 179 proposed the creation of a Patient Ombudsman to address concerns relating to hospitals and long-term care homes – and that office would, in turn, come under my investigative authority. As for children's aid societies, the bill proposed to give the Provincial Advocate for Children and Youth new investigative powers and the ability to address matters relating to children and youth involved in the child protection system.

In the spirit of co-operation and respect that characterizes the relationship between my Office and government administrators, I was consulted and provided with an opportunity to express my views as Bill 179 was drafted. I noted that, as I have long argued in my reports, I believe the organizations most urgently in need of my Office's oversight are hospitals, long-term care homes and children's aid societies. These are areas that every other parliamentary ombudsman in the country has been given the power to oversee, and that affect citizens who are among our most vulnerable. (Indeed, they are the areas that the previous premier told me he would prefer to target first.) That said, however, I appreciated that the bill proposed to open the entire MUSH sector to more oversight than ever before. It is the prerogative of our elected officials to make broad public policy decisions on behalf of Ontarians, and as an officer of the Legislature, I respect those decisions.

The dissolution of the Legislative Assembly on May 2, 2014, of course, killed Bill 179 along with others on the order paper. Still, this important legislative effort was not in vain. It reflected a commitment to increasing accountability in the MUSH sector, an area where Ontario lags behind the rest of Canada. Whatever happens next, support for these measures has been legitimized and imprinted on the provincial consciousness. Our Office stands ready to help the thousands of Ontarians who have complained to us about MUSH organizations. In 2013-2014, we had to turn away a record **3,400** such complaints, a **34%** increase over the previous year.

> "As you know, the proposed legislation [Bill 179] would expand the mandate of the Ombudsman's Office into entirely new areas. I note, with gratitude, that you and your staff provided a number of constructive comments that went into the drafting of the proposed legislation and were instrumental in refining and improving the bill....
>
> "I firmly believe that this proposed legislation is extremely important, and represents a historic opportunity to improve accountability and transparency in Ontario – and, simultaneously, expand the mandate of the Ombudsman's Office. I am completely convinced that Ontario, and Ontarians, will be better off for having this initiative move forward."
>
> *Letter from Premier Kathleen Wynne, March 25, 2014*

No Fuss over US

Regardless of Bill 179's fate, it put a welcome public spotlight on the need for Ombudsman oversight of **m**unicipalities, **u**niversities and **s**chool boards, which account for a significant share of provincial spending (respectively: $3.5 billion, $3.5 billion and $23.2 billion). Recent scandals involving allegations of financial irregularities, conflicts of interest, and other notorious conduct in the "**MUS**" sector also underscore the need for increased oversight and accountability measures. For instance, **2013-2014** saw a number of prominent mayors, one large school board, and a public university embroiled in controversy. Citizens continue to express dissatisfaction and frustration with the decisions, policies and practices of **MUS** organizations. Despite having no jurisdiction in these areas, my Office has received **8,992** complaints and inquiries since 2005 about municipalities, **358** about universities and **982** about school boards, all of which we have had to turn away.

Reaction to Bill 179 from this sector was also telling. For the most part, the school board and university communities were publicly silent about the prospect of Ombudsman oversight; several school trustees expressed support for it, while at least one university president took the attitude "we have nothing to hide." The Ontario wing of the Canadian Federation of Students lauded the fact that the bill would finally give university students the same recourse to complain to our Office that college students already enjoy.

The conspicuous exception to this trend came from the municipal sector.

The Municipal Sky is Not Falling

Bill 179 would have given my Office the authority to investigate individual and systemic issues relating to the administration of municipal government, once local complaint and appeal mechanisms had been exhausted. In other words, the same authority we have exercised over hundreds of provincial government organizations for 39 years.

At present, our only authority over municipalities is to investigate complaints about closed meetings – and only in municipalities that have not appointed their own investigators. (The **159** complaints we received about closed municipal meetings in fiscal 2013-2014 were handled by our **Open Meeting Law Enforcement Team**, or

OMLET; these cases will be detailed in our separate **OMLET Annual Report** later this year.) Bill 179 would also have alleviated the patchwork nature of this system by allowing us to address concerns about closed meeting investigations conducted by locally appointed investigators.

However, the Association of Municipalities of Ontario (AMO), representing Ontario's 444 municipalities, lost no time in warning its members about the perils it predicted would accompany expansion of my Office's oversight into the municipal sector. It cautioned that it would result in provincial micromanagement, duplication of the work of existing accountability offices, increased costs for municipalities and "more red tape" for their citizens. With AMO's encouragement, some municipal councils echoed these "Chicken Little" protestations, parroting AMO's criticism of the bill in a series of resolutions and letters to the provincial government.

We heard a similar refrain in 2006, when the prospect of my Office acting as a default municipal closed meeting complaint investigator was first explored. Today, we successfully act for close to half of Ontario's municipalities in this area – and so far, the sky has not fallen.

Ombudsman Basics 101

Still, this municipal anxiety appears to reflect a broad and fundamental misunderstanding of the function of my Office, which demonstrably does not get involved in political processes. My statutory authority has always been confined to investigating administrative conduct and issuing non-binding recommendations. While I exercise the power of moral suasion, and attempt to persuade officials to implement systemic remedies and resolve individual disputes, they are always free to reject my suggestions.

Concerns about red tape and increased costs are similarly unfounded. On the contrary, the beauty of ombudsman oversight is that it provides a cost-effective alternative to dispute resolution through the courts. Ombudsman investigations involve neutral fact-finding, not adversarial posturing. No one is in any legal jeopardy or requires a lawyer to participate in our process.

At the provincial level, our intervention has helped organizations stave off expensive lawsuits. Most cases are resolved amiably and expeditiously without formal investigation. In many instances, our reviews provide independent and credible affirmation that government officials have acted appropriately, avoiding protracted and costly conflicts.

As for duplication of existing accountability offices, while many municipal officials pledge support for these in principle, they tend to avoid them in practice. At present, there is only one municipal ombudsman and a handful of integrity commissioners and auditors general across Ontario – and many of them have proven vulnerable to political interference by the councils to which they report. Some have had their terms reduced or even abolished after issuing adverse reports. Ombudsman oversight would support, not supplant, the role of local accountability officers. We would also have the unique ability to conduct systemic investigations across the entire municipal governance system.

Expansion of Ombudsman authority into municipalities should not be viewed as a provincial punishment for a few municipal officials behaving badly. It should be embraced as a healthy check and balance that would serve to promote public confidence in local governance, through recourse to an independent, impartial and credible investigative process.

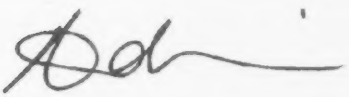
Moreover, it is not a radical or novel proposal. It is an opportunity for Ontario to catch up to the other five jurisdictions – British Columbia, Manitoba, New Brunswick, Nova Scotia and Yukon – whose ombudsmen have had the authority to investigate municipal matters for many years (in two cases, since the 1970s). Far from usurping local democracy, this has led to many positive changes at the local level in these provinces, including improvements to by-law enforcement, communication with residents, council conflict-of-interest policies, and financial accountability. They have strengthened, not detracted from local governance.

Building on Success

As I write this message, Ontario is on the brink of provincial and municipal elections. There is a sense of anticipation and excitement in the air as we look towards the future. Elections provide an excellent opportunity for reflection, and I am hopeful that the recent success in promoting enhanced Ombudsman oversight in the broader public sector will resonate with individuals engaged with both levels of government.

In the coming year, I intend to encourage the provincial government, once it is reconstituted, to revive efforts to bring in legislative reform to address systemic problems that my Office has flagged, but remain unresolved. I will also continue to work towards dispelling the myths around Ombudsman oversight, and championing accountability, transparency and fairness on behalf of Ontario's citizens.

This report is a testament to how our Office does just that on a daily basis. We have also **shared our investigative techniques** by training other watchdog offices across Canada and around the world, and engaged a wide public following on **social media** and through our myriad **communications**. I invite anyone curious about what we do to peruse these pages, and I welcome your feedback.



André Marin
Ombudsman

June 2014

The Year in Review

> "Fighting the bureaucracy is a difficult experience, to put it mildly. However, having the Ombudsman's Office there to provide guidance in navigating the bureaucracy has been crucial to maintaining our sanity."
>
> *Letter from complainant*

The Ombudsman's Office received a record number of cases between April 1, 2013 and March 31, 2014. There were **26,999** complaints and inquiries, a significant increase of about **37%** over 2012-2013.

Approximately **72%** of all complaints were dealt with within two weeks. In order to ensure efficient handling of such a high volume of complaints and to avoid backlogs, our Office triages cases by assigning them to teams.

Early Resolution Officers are the first line of complaint intake, and resolve cases that can be dealt with quickly. Examples of successful case resolutions can be found in the **Case Summaries** section of this report.

Cases that cannot be informally resolved are referred to our team of **Investigators** and/or brought to the attention of senior government officials. These two teams and senior managers also do the bulk of the Ombudsman's proactive work – flagging complaint trends in the most complained about ministries to allow the government a chance to address them before they grow. Examples of this proactive work can be found in the next section of this report, **Operations Overview: Complaint Trends and Significant Cases**.

These two teams also work closely with the **Special Ombudsman Response Team (SORT)** to identify, investigate and recommend solutions to major systemic problems potentially affecting large numbers of people.

In two high-volume SORT investigations this year – one involving Hydro One's billing and customer service, and the other focusing on the Ministry of Community and Social Services' provision of services for adults with developmental disabilities who are in crisis – Early Resolution Officers and Investigators worked to resolve hundreds of individual cases while SORT tackled the broader issues. These cases are summarized in the section of the report entitled **Systemic Investigations: Special Ombudsman Response Team (SORT)**.

To learn more about our Office's structure, please see **Appendix 3 – About the Office**.

Operations Overview: Complaint Trends and Significant Cases

This section highlights, by relevant ministry in alphabetical order, key cases and complaint trends that were brought to the government's attention this year. For a list of the top 15 most complained about ministries and programs, as well as a breakdown of all complaints by ministry, please see **Appendix 1 – Complaint Statistics**.

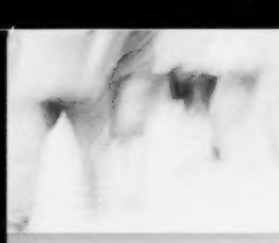
MINISTRY OF THE ATTORNEY GENERAL

Landlord and Tenant Board

Complaints about the Landlord and Tenant Board have been on the rise since 2010-2011 (when we received 99), and remained steady this year at **138** (down marginally from last year's 139). Landlords and tenants raised a variety of issues, including poor customer service, clerical errors, and delay.

For example, four landlords complained to us about a "legal loophole" that enabled tenants to avoid paying rent for extended periods of time by making groundless appeals to the Board when they are ordered evicted. These landlords were owed thousands of dollars and could not pursue court claims against the tenants, who had left the province.

In a similar case that did go to court in 2012, Ontario Superior Court Justice Ted Matlow suggested the law be changed to require tenants to obtain a court's permission before they can appeal eviction orders. He stated:



> "[T]here is a growing practice by unscrupulous residential tenants to manipulate the law improperly, and often dishonestly, to enable them to remain in their rented premises for long periods of time without having to pay rent to their landlords. It is [a] practice that imposes an unfair hardship on landlords and reflects badly on the civil justice system in Ontario. It calls for the government, the Landlord and Tenant Board and this court to respond."

Although the Board has the authority to require tenants to pay rent to it in trust, Board officials told our Office it is generally more expedient for tenants to deliver rent arrears directly to their landlords. Ministry of Municipal Affairs and Housing officials also told us it is not common for tenants to exploit the legislative framework in this way, and that changing the legislation to require tenants to seek leave to appeal would further delay eviction proceedings. Ombudsman staff will continue to monitor similar complaints about the Board.

We also spoke to the Board about complaints that signalled a need for better training of its adjudicators and staff. In one case, a tenant complained that an adjudicator made critical comments at a hearing about her landlord's conduct and indicated an order would be issued in the tenant's favour – but the Board's written decision completely dismissed the tenant's application. Ombudsman staff suggested the Board use the case in training adjudicators to emphasize that they should reserve their comments until a final decision is issued. In another case, the Board undertook to improve staff training after several landlords complained that the Board had provided them with the wrong forms, resulting in delays in having their issues adjudicated.

Office of the Public Guardian and Trustee

The Office of the Public Guardian and Trustee (OPGT) handles the financial affairs of Ontarians who do not have the capacity to do so themselves. It continues to be a leading source of complaints to the Ombudsman, with **180** complaints in 2013-2014, up from the past two years (162 in 2012-2013; 130 in 2011-2012).

As in previous years, the most common complaints relate to poor customer service, delays and communication failures, as well as disagreement with the OPGT's decisions. Senior Ombudsman staff continue to meet regularly with OPGT leadership to discuss individual cases and potential systemic concerns.

In one case we raised, a man complained that the OPGT, which paid bills on his behalf, paid his telephone and Internet provider bills multiple times. The man was on a fixed income and was anxious about the unnecessary payments. We discovered this happened inadvertently because the man's client representative was on an extended leave and the other employees who took over his file paid the bills without noticing they had already been paid. Ombudsman staff flagged this problem to OPGT senior staff. The OPGT assigned a working group of managers to review how files are managed when client representatives are on extended absences.

In another case, a woman and her social worker attempted unsuccessfully for five months to reach her OPGT client representative to obtain a document that would entitle her to see a naturopathic doctor at a reduced cost. After Ombudsman staff intervened, the OPGT apologized for the unreasonable delay.

Many OPGT clients, their family members and social workers are not aware that there is an internal complaint process and they can call management if they have not received a response or are dissatisfied. Our Office has raised this with the OPGT and suggested it make more information available to clients and the public.

Senior OPGT staff are working on several projects to streamline and improve their internal processes and service delivery. We will continue to monitor their progress in implementing these changes.

MINISTRY OF CHILDREN AND YOUTH SERVICES

Services for children with special needs

Complaints about services and treatment for children with special needs remained relatively consistent in 2013-2014 – there were **89**, down slightly from 91 the previous year, but considerably more than the 47 received in 2011-2012. Families raised concerns about an overall lack of funding and services available for children with special needs, as well as about policies, procedures and decisions regarding eligibility for such services.

Ombudsman staff worked with community agencies and the Ministry's regional offices to connect families with available services and funds for their children. The Ministry also reorganized its regional offices and reduced their number, while promising more integrated service delivery for children and adults with special needs.

Ombudsman staff regularly flag urgent cases to senior Ministry officials. In one such case, when the mother of a nine-year-old girl with severe autism and aggressive behaviours told us the child was going to be discharged from a psychiatric unit without any support services in place for the family, we contacted a senior manager who had his staff arrange for short-term emergency support at the family's home until a long-term plan could be developed. The local hospital then agreed to keep the girl for two more weeks while the necessary services were put into place, and ultimately she was assessed for a residential placement.

In another case, the mother of a nine-year-old boy with serious mental health issues contacted our Office after waiting eight weeks for the Ministry to approve her request for complex special needs funding – twice as long as she was told it would take. Immediately after Ombudsman staff contacted the Ministry, her funding was approved in full.

MINISTRY OF COMMUNITY AND SOCIAL SERVICES

Family Responsibility Office

The Family Responsibility Office (FRO) is responsible for the enforcement of court-ordered child and spousal support in Ontario, and is consistently a top source of complaints to the Ombudsman. In 2013-2014, complaints were up significantly – to **1,157** complaints, 46% higher than the 794 received in 2012-2013. It is consistently the most complained about provincial organization, exceeded this year only by Hydro One – the subject of a Special Ombudsman Response Team investigation that accounted for 6,961 cases as of March 31, 2014.

As we have done for several years, senior Ombudsman staff meet regularly with FRO's senior team to address complaint trends and egregious matters, and FRO managers have been co-operative, responsive and proactive in addressing the issues raised. Senior management at FRO have committed to improving their service and have welcomed the Ombudsman's involvement, which has helped them not only resolve hundreds of individual cases but address potential systemic problems.

The most common FRO complaints we receive involve inadequate or delayed enforcement of support orders and insufficient communication with clients. For example, we discovered the FRO had not taken aggressive enforcement action against a man who owed **$16,000** in child support, because he claimed to have a pending court action to have his support obligations changed. In fact, there was no such action and FRO staff had not verified it. Once they learned this was just a stalling tactic, they took aggressive enforcement action by suspending the man's driver's licence.

Ombudsman staff also noted a trend in FRO complaints involving inter-jurisdictional support orders – cases where the FRO works with outside enforcement agencies to collect support payments from payors who do not live in Ontario. We identified several incidents of communication breakdown in these cases.

Delay in registering one family's case with an agency outside of Canada resulted in a lost opportunity to locate a father who owed more than **$18,000** in child support. FRO officials made a series of mistakes in this case, including failing to file the proper paperwork in the father's country for more than a year, and incorrectly informing the children's mother that this had been done. By the time the FRO's errors had been rectified and the file was properly registered in the father's country for enforcement, he had disappeared.

As a result, FRO management engaged a consultant to review how interjurisdictional cases are processed. Ombudsman staff are monitoring the outcome of this review.

Examples of other FRO cases we have helped resolve can be found the **Case Summaries** section of this report.

FRO payment "assignments" to the Ontario Disability Support Program

Proactive flagging of FRO complaints also led us to uncover a grave miscommunication between it and the Ontario Disability Support Program (ODSP), that deprived families of hundreds of thousands of dollars over several years. The cases all involved people who were entitled to family support payments collected through the FRO, while they were receiving social assistance from the ODSP.

Under the normal process, these ODSP recipients enter an arrangement called an "assignment," where the FRO forwards support payments collected from their ex-spouses to the ODSP. What we discovered was a communication breakdown in cases where the families were no longer receiving ODSP assistance. Because the ODSP failed to cancel the assignments, the FRO continued to forward the families' support payments to the ODSP, and the money sat in an account.

One woman who complained to our Office did not receive **14 years'** worth of support payments – more than **$8,000** in total – because FRO sent them to ODSP.

She was never made aware that the payments were being collected or that she and her children were entitled to them.

Ombudsman staff raised this issue with the Social Assistance and Municipal Operations Branch of the Ministry of Community and Social Services. We learned that an employee there had manually reviewed ODSP records on her own initiative, and identified at least **350** similar cases.

To date, the Ministry has reimbursed these families more than $845,000, and senior officials have agreed to report back to the Ombudsman on how the Ministry will deal with cancelling "assignment" arrangements with the FRO when clients stop receiving social assistance. The Ministry's plan includes reviewing its database to identify and reimburse any other former ODSP recipients who are owed money, improving staff training and ensuring that recipients with FRO assignments are regularly informed of the status of their support payments.

Thistletown Regional Centre – Adults with special needs

Last year, we reported on the Ministry's plan to close Thistletown Regional Centre, a mental health facility that offered specialized services to hundreds of children and youths with complex special needs. It also provided residential care for 13 adults, some of whom had been there since early childhood.

Families of six of these adult residents complained to us about the decision to close Thistletown and relocate their relatives. As we reported last year, our review found the families were given inaccurate and inadequate information about the transition process. Ombudsman staff met with senior Ministry officials, who committed to improve communication with the families and confirmed that the residents would not be relocated until appropriate placements were found. The planned closure date was extended a year, to March 31, 2014.

By September 2013, two of the six adults were relocated, but serious concerns were raised about the others. A community agency was given funds by the Ministry to purchase a new group home for them, and met with the families to review the residents' needs. However, the families complained that the home it purchased did not meet specific requirements, based on assessments of the residents, that it not be close to busy roads, bodies of water, or other residential dwellings with animals and children. An alternative location was found that satisfied the needs of three of the residents, but because it was close to water, the fourth family raised concerns that it would pose a danger for their relative, who had a history of running from caregivers and being obsessed with water.

The Ministry initially would not consider any other placements for the man and suggested he be cared for at home, although his parents were seniors and the man had not lived at home for 15 years. After Ombudsman staff raised concerns about this with senior Ministry officials, they agreed to look into establishing a new group home that would meet the man's needs and accommodate other residents in future. A temporary placement was found for him in the meantime.

In a letter of thanks to Ombudsman staff, the man's father wrote:

> "He cannot say it himself so I will say it for our family. Thank you. You made no promises and we still have a long journey ahead, but you cared enough to listen."

MINISTRY OF COMMUNITY SAFETY AND CORRECTIONAL SERVICES

Correctional facilities – Complaints from inmates

The province's correctional facilities have historically been a top source of complaints to the Ombudsman's office. Combined, they accounted for **3,839** complaints in 2013-2014, down from 4,477 in 2012-2013. A breakdown of the top 10 most complained about correctional facilities can be found in **Appendix 1**.

Our strategy to ensure complaints from correctional institutions are dealt with quickly and efficiently has been to prioritize serious health and safety issues. These involve inmate concerns about the use of excessive force by correctional staff

(the subject of last year's systemic investigation report, *The Code*), prolonged or inappropriate segregation, inadequate medical treatment, and inmate-on-inmate assaults.

Many inmates complained to us this year about being held too long in **segregation** – normally, this means they are confined to a cell alone and separated from the general population. Inmates may be placed in segregation because they pose a threat to themselves or others, because of misconduct, or at their own request.

By law, (*Ministry of Correctional Services Act*, Reg. 778), all segregation placements must be reviewed by the correctional facility every five days, and a special report must be filed if an inmate is kept in segregation for 30 continuous days or more. But inmates complained to us that they were kept in segregation for months on end. Some felt anxious and even suicidal; several had pre-existing mental health issues, making them particularly vulnerable. We also found that in many cases, the facility did not conduct the required reviews – in fact, some senior staff were not even aware of the review and reporting requirements.

We reviewed a number of egregious cases with senior Ministry officials, who provided the Ombudsman with their plan to ensure segregation reports are completed as required at all correctional facilities. Ombudsman staff are closely monitoring complaints received and the Ministry's implementation of its plan.

Medical treatment accounts for a high volume of inmate complaints – in particular, lack of access to medication or medical staff. Many complaints involve health care staff not communicating with community physicians, institutional doctors refusing to prescribe medications, missed or delayed medication due to lockdowns, and medication being cut off without an alternative. We also received a large number of complaints from inmates with serious mental illnesses who faced long waits to see a psychiatrist, and about a lack of services for female inmates with mental health issues.

One inmate who had painful kidney issues complained that she had to wait seven days after a nurse said she would be sent to hospital for an examination. After Ombudsman staff contacted the facility's health care manager, the woman was immediately taken to hospital, where doctors recommended she be seen by a specialist.

Another inmate who had been taking morphine by prescription for nine months complained he was abruptly cut off the drug, causing him to go through painful withdrawal with no medical care. Our office confirmed with the Ministry that the man should have been prescribed alternative medication and monitored. They arranged for him to receive the proper medical attention.

While complaints about **inmate-on-inmate assault** have trended downward in the past year, we have monitored them to ensure Ministry policies are being followed. For example, in one case, we inquired why no internal investigation was done after an inmate was injured so badly by another that he required surgery to his face. We have also identified inconsistencies between correctional facilities in determining when to investigate such incidents.

The Ministry advised us that it has directed all facilities to conduct internal investigations at the local level whenever there are serious injuries in inmate-on-inmate assaults. We continue to track complaints on this issue and to monitor the Ministry's actions.

MINISTRY OF HEALTH AND LONG-TERM CARE

Exceptional Access Program

The Ombudsman often receives complaints from people who have asked the province for help in paying for drugs that are not covered by existing programs. We received **34** complaints about the Exceptional Access Program (EAP) and the lack of a process to allow for individual patients' needs for specific drugs.

For example, the Ministry denied a physician's request for a specific medication in a granule format for a teenager who has complex developmental disabilities and receives food through a tube, because the drug was not on any of the Ministry's approved formularies. It also denied two patients who needed an injectable, liquid form of Gravol to manage nausea related to Crohn's disease, because it only approves the drug for patients in palliative care.

In another case, it denied a physician's request to fund a drug that was helping a woman with a potentially terminal vascular disease (at a cost of $3,000 per month), on the grounds that there was not enough evidence that the drug was effective.

Although we have succeeded in persuading EAP officials to review decisions in some cases (see **"The Right Prescription"** in the **Case Summaries** section of this report), the evidence from these cases has raised the Ombudsman's concern about whether the EAP truly addresses exceptional cases, where patients' circumstances may not satisfy rigid eligibility criteria.

At present, there is no mechanism within the Ministry to review a drug funding request based on a patient's individual circumstances, such as his/her age, multiple medical conditions, ability to tolerate certain medications or his/her physician's specific recommendations. The Ombudsman is concerned about the lack of a mechanism to address these exceptional circumstances, and our staff have been monitoring the Ministry's response to his concerns. The Ministry and Ombudsman staff continue to engage in discussions relating to individual circumstances.

At present, the Ombudsman is evaluating whether or not a formal investigation is warranted.

Community Care Access Centres

Ontario's 14 Community Care Access Centres (CCACs) co-ordinate support services for people who require nursing services or assistance with personal care, such as help with dressing, eating, using the bathroom, etc., at home.

In 2013-2014, the Ombudsman's Office received **122** complaints about CCACs – most regarding the number of hours of service offered and the service quality – and CCACs across the province have been highly co-operative with our Office in resolving individual complaints, to the benefit of many patients.

In one case, a CCAC reduced personal services for a 12-year-old girl with cerebral palsy, ADHD and a brain injury from 60 hours a month to 30. Ombudsman staff asked the CCAC's client services supervisor to reassess her situation. The girl's service hours were increased to 40 hours per month.

Similarly, we intervened after a CCAC informed a mother who was caring for her 21-year-old son (who needed help with dressing, showering and eating) that it was cutting his monthly service hours to 60 from 70 under new budgetary guidelines. The CCAC advised us that these measures were meant to apply to new clients; since the man was not a new client, the CCAC agreed to reinstate his service to 70 hours per month.

MINISTRY OF NATURAL RESOURCES

Natural Heritage, Lands, and Protected Spaces Branch

In last year's Annual Report, the Ombudsman reported that the Ministry was looking at ways to address an inequity in the *Aggregate Resources Act* stemming from a complaint to our Office from an aggregate business operator. Aggregates – gravel, sand, stone, etc. – are used in construction projects, and under the Act, some designated geographic areas are subject to a system of licensing, monitoring, inspection and enforcement, while undesignated areas are not.

The operator's complaint was that licensed aggregate businesses in designated areas are at a competitive disadvantage when bidding against unlicensed operators in undesignated areas. He argued the rules should be consistent across the province.

The Ministry's policy initiatives were put on hold after the Ontario Legislature directed the Standing Committee on General Government to review and develop recommendations to strengthen the *Aggregate Resources Act*. The committee released its report in October 2013, which included 38 findings and recommendations, including improvements to public information on aggregate operations and the licensing process, as well as an increase in the annual fees.

In February 2014, the Ministry announced it would consult with stakeholders and the public on the recommendations, after which it will propose policy and regulatory changes. The Ministry confirmed to the Ombudsman that the issue of designation will be discussed as part of this process.

MINISTRY OF TRANSPORTATION

Licensing Services Branch – "Ghost Licences"

The Ombudsman first reported in 2011-2012 on the potential public safety implications of the Ministry's practice of creating "master licence" records in its computer system. The purpose of these records is to store information about drivers for whom no existing licence can be found in the system. They are intended to serve as placeholders in the Ministry's database, and wherever possible, they are matched with the driver's official licence and the duplicate "master" is eliminated.

However, as we revealed that year in the case of one convicted drunk driver, if the information on the existing licence and the master licence do not match exactly – that is, if there is an error in the address or the spelling of a name – the duplicate record remains in the system. In the case of the drunk driver, this meant that when he was convicted and banned from driving, the conviction was added to the "master" record, not his existing licence – which he continued to use.

Our inquiries with the Ministry revealed that more than **1.1 million** master licence records had been created since 1966 – **235,000** of which related to Ontarians (the rest were created to store information about out-of-province drivers). In 2012-2013, it identified some **13,866** of these as potential duplicates of current Ontario licences – of which **1,039**[1] had been flagged for suspension. Of those, **138** were considered "high risk," i.e., suspended for criminal offences.

Since then, the Ministry has confirmed **552** of the licences flagged for suspension had "master" duplicates in its system – that is, exact matches were found. Of those, **99** related to "high risk" drivers and **274** were "medium risk" (suspended for medical reasons). The Ministry contacted all affected drivers.

While recognizing the Ministry's progress on this issue, the Ombudsman remained concerned about what he called "ghost licences," since its manual review process was limited to identifying only those records for which an **exact match** could be found. It could not detect duplicates that had small variations in the spelling of drivers' names or addresses. After considerable prompting from our Office on this issue, the Ministry agreed to ask the Ministry of Finance's Internal Audit Division to conduct an independent audit of the licensing control system.

The audit, completed in March 2014, identified several problems with the Ministry's legacy computer system and pinpointed areas within the master record process that are inherently prone to error and duplication. It made recommendations to improve the accuracy of Ministry records.

Ministry officials told us they are reviewing the recommended changes and their cost implications, and pledged to provide the Ombudsman with their timelines for addressing them. Once we receive this information, the Ombudsman will review it and determine whether or not a formal investigation is warranted.

Licence suspension letters

In another case with potential systemic implications, a woman complained that the Ministry had arbitrarily cancelled her driver's licence without notification in August 2010, because she had failed to pay a $150 licence reinstatement fee. She had no knowledge of the cancellation until September 2013, when the Ministry advised her that her licence had now been expired for three years, meaning she would have to be retested and go through the graduated licensing process again if she wished to resume driving in Ontario.

Ombudsman staff reviewed the "Notice of Reinstatement" form that the Ministry sent the woman in 2010, after a temporary suspension of her licence. The form states in its first paragraph that the driver's "authority to drive has been reinstated." It is only in the fourth paragraph that the driver is informed there is a $150 fee for licence reinstatement. And the notification that failure to pay the $150 fee will result in immediate invalidation of the licence is on small print on the back of the form.

The woman noted that she continued to drive for three years – she had even been stopped by police and attended court for driving infractions – without anyone advising her that her licence was invalid.

Ombudsman staff spoke with Ministry officials about the confusing form and the lack of any specific notification to drivers whose licences are cancelled because of failure to pay the fee. The Ministry is working on improvements to the form. The Ombudsman will monitor its response and has not ruled out a formal systemic investigation.

[1] A year ago, the Ministry reported this number as 1,050, but it has since corrected it to 1,039.

Systemic Investigations: Special Ombudsman Response Team (SORT)

Created in 2005, the **Special Ombudsman Response Team (SORT)** is a designated group of Ombudsman investigators and other staff tasked with our Office's broad systemic investigations. These cases target complex problems potentially affecting large numbers of Ontarians and can involve thousands of complaints, hundreds of interviews, exhaustive document review and intensive field work.

The Ombudsman's recommendations stemming from SORT investigations – more than 30 since 2005 – have been overwhelmingly accepted by the government, resulting in widespread improvements to programs and services. SORT staff follow up to ensure recommendations are implemented. Investigations can be reopened if warranted.

SORT staff also work with Early Resolution Officers and Investigators to ensure urgent individual issues identified by complainants in complex investigations are dealt with – for example, in the ongoing cases involving Hydro One and adults with developmental disabilities. Examples of how we have handled this two-pronged approach are included in the summaries of those SORT investigations.

The SORT investigation model also forms the basis for the Ontario Ombudsman's training course "Sharpening Your Teeth," which has trained hundreds of ombudsmen and investigators from across Canada and around the world since 2007. More information on this can be found in the **Training and Consultation** section of this report.

NEW AND ONGOING SORT INVESTIGATIONS

Hydro One – Ministry of Energy

In the wake of a sharp spike in complaints about billing and customer service at Hydro One – complaints rose from **232** in fiscal 2011-2012 to more than **600** in the first 10 months of fiscal 2013-2014 – the Ombudsman launched an investigation in February 2014, into the transparency of the utility's billing practices and the timeliness and effectiveness of its process for responding to customer concerns. By March 31, 2014, it had garnered **6,961** complaints, and the number continues to grow – the most complaints, by far, that our Office has ever received about a single government organization.

Hydro One customers across the province complained about receiving no bills, delayed bills, multiple bills or estimated bills covering prolonged periods – resulting in alarmingly high "catch-up" bills. Some customers who had automatic payment agreements with Hydro One were distressed when it withdrew unexpectedly large sums of money from their bank accounts. Many also found that when they complained to Hydro One – or even sought information on how their bills were calculated – they were met with more frustrating delays and poor customer service.

The response to the investigation announcement from the public, Hydro One and government was immediate. More than **1,500** new complaints poured in during the first four days. Along with the Premier and Minister of Energy, Hydro One's CEO pledged full co-operation with the investigation. The CEO wrote to all Hydro One customers to acknowledge serious problems with billing and customer service, which he said arose from "unanticipated" issues with the introduction of a new system implemented in May 2013.

> "I want to assure you of our complete co-operation. I have every confidence in Hydro One and the Ministry of Energy to provide detailed and timely access to any and all information that you require."
>
> *Bob Chiarelli, Minister of Energy*
> *Letter to Ombudsman, February 12, 2014*

> "I was pleased to hear that you are launching an investigation into Hydro One's billing and customer service practices. Hydro One complaints are among the most frequent cases that I receive in my constituency office.... I look forward to your final report, and I hope that your investigation will bring accountability and transparency to Hydro One."
>
> *PC MPP Randy Pettapiece, email to Ombudsman, February 5, 2014*

> "This investigation, I hope, will help get to the bottom of why these bills are so out of whack."
>
> *NDP Leader Andrea Horwath, quoted in the* Toronto Sun, *February 5, 2014*

February-March 2014: Our Hydro One investigation made several newspaper front pages (top left), and Ombudsman André Marin (at keyboard, top right) helped staff answer the flood of initial calls. Ombudsman managers (foreground, bottom) also began weekly meetings with senior Hydro One staff to triage complaints.

Since the launch of the Ombudsman's investigation, Hydro One has implemented several short-term measures to alleviate problems. The CEO outlined these in letters to all MPPs and the Ombudsman in early April 2014. They included:

- Waiving late payment charges;
- Providing service charge credits and interest-free payment instalment plans;
- Pledging not to disconnect any customer for billing issues;
- Contacting customers before sending large or unexpected bills;
- Obtaining consent before taking an "abnormally large" sum from a customer's bank account; and
- Setting a 10-day turnaround time for escalated complaints.

The investigation is progressing on two fronts, as Ombudsman staff deal with the broad systemic issues while helping thousands of people with their individual cases.

Systemic investigation: The Ombudsman set a deadline of nine months to complete the field investigation, after which a report and recommendations will be drafted. The Special Ombudsman Response Team has begun interviews with witnesses, who will include Hydro One staff, customers, stakeholders and utilities in other jurisdictions.

Other investigative steps taken to date include:

- Briefings on Hydro One's billing and complaint handling processes;
- Site inspections at Hydro One call centres;
- Meetings with stakeholders and the Ontario Energy Board; and
- Obtaining and reviewing more than 19,000 pages of Hydro One documentation, with more to come.

SORT investigators are also reviewing recurring themes and problems arising from individual complaints, including:

- Lack of transparency in billing (how amounts were calculated);
- Lack of communication and delays in dealing with customers;
- Poor training of customer service and billing staff; and
- Inconsistency in how complaints are resolved.

Individual cases: A dedicated team of 10 Early Resolution Officers and Investigators is working with a team set up by Hydro One to resolve thousands of individual complaints as quickly as possible. In the first months of the investigation, staff across our Office worked to triage and respond to the extraordinarily high volume of complaints – identifying some **3,900** to bring forward to Hydro One for action. Examples of some of the cases that have been resolved can be found in the **Case Summaries** section of this report.

> "Today I was able to phone the Office of the Ombudsman to inform them that they are able to close my case with Hydro One. Would like to thank all who helped.... It was wonderful to be able to go somewhere when I was unable to get any results myself."
>
> *Complainant via Facebook*

De-escalation direction to police – Ministry of Community Safety and Correctional Services

On July 27, 2013, 18-year-old Sammy Yatim was shot and killed – alone on a Toronto streetcar, where he had been seen holding a small knife – by a member of the Toronto Police Service. The incident, captured on video and widely shared via social media, sparked an outpouring of public concern about when, why and how police in Ontario use lethal force.

Among the questions raised: What de-escalation techniques are police across the province trained to use in such cases? After conducting a preliminary assessment, the Ombudsman launched an investigation on August 8, 2013 into the direction provided by the Ministry of Community Safety and Correctional Services to Ontario's police services for de-escalating situations that could potentially result in the use of force.

As the Ombudsman noted at his news conference announcing the investigation, the issue has been raised repeatedly by juries at coroner's inquests, but few of their recommendations have been heeded, and police de-escalation policies appear to vary widely across the province.

> "It seems to be like [the movie] *Groundhog Day*: Inquest after inquest, police shooting after police shooting. What's happened to all these recommendations in 20 years? Have they been gathering dust in some bin somewhere?
>
> "Right now, how de-escalation happens in London, Ottawa or Toronto is as diverse as the cities."
>
> *Ontario Ombudsman André Marin, at press conference announcing investigation, August 8, 2013*

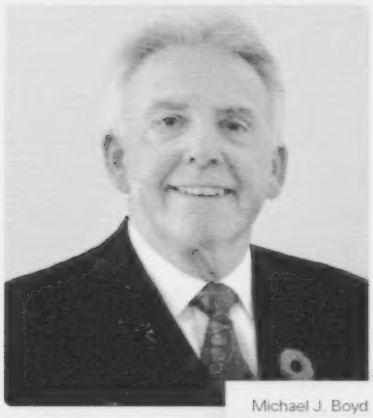
The Ministry has overall responsibility for policing in Ontario. Although it plays no role in operational decisions, it creates and implements guidelines that provide direction for police services on broad policy issues. For example, after a public outcry over a spate of deaths in police pursuits in the late 1990s, the Ministry introduced a regulation that stipulated how police services should conduct police pursuits, including mandating training for frontline officers and supervisors.

The Ombudsman has received **176** complaints and submissions relating to this investigation, including input from retired chiefs of police, serving officers, psychologists, psychiatrists and academics. The Ombudsman and staff have also met with family members of people who died as a result of police use of lethal force.

To date, SORT investigators have conducted more than 50 interviews, observed de-escalation training sessions at the Ontario Police College and by the Ontario Provincial Police, Durham Regional Police Service and the Peel Regional Police Service, and attended a recent inquest in Toronto into civilian deaths where de-escalation was an issue. They will also examine best practices in other jurisdictions in Canada and elsewhere.

Special advisors and co-operation of police: In November 2013, the Ombudsman appointed two distinguished former police chiefs as special advisors to the investigation, to share their expertise and advice on best practices and potential recommendations. Senator Vern White, former chief of the Ottawa Police Service

and Durham Regional Police Service and former Assistant Commissioner of the RCMP, and Mike Boyd, former chief of the Edmonton Police Service and former Deputy Chief and interim Chief of the Toronto Police Service, have both offered their services pro bono.



Michael J. Boyd

Hon. Vern White

> "I welcome the chance to share my experience and that of the thousands of police personnel I've worked with at all levels, in an effort to improve how we serve the public."
>
> *Michael J. Boyd*

> "The Ombudsman's invitation to police chiefs to provide input in this investigation has significant potential to benefit all police as well as the public. I am glad to contribute my expertise toward this crucial issue as a way of giving back to the Ontario public."
>
> *Hon. Vern White*

As part of the investigation, the Ombudsman has also written to every police chief, police association and police services board across the province to invite their co-operation with and input into the investigation.

As of the end of March 2014, some **23** responses had been received from police chiefs, **11** from police services boards, and **one** from a police association. While some chiefs and police services boards have provided helpful information so far on their training and practices relating to de-escalation, most of those who responded declined, stating only that the responsibility for oversight of policing in the province lies with the Ministry. The nature of the responses received will be included in the Ombudsman's final report.

> "We are grateful that this investigation will further public dialogue on police procedures and acceptable de-escalation tactics, and that this inquiry will hopefully, finally, lead to the implementation, not just recommendation, of safe conflict resolution procedures."
>
> *Statement by family of Sammy Yatim, August 8, 2013*

Unlicensed daycares – Ministry of Education

When two-year-old Eva Ravikovich died in an unlicensed home daycare facility in Vaughan on July 8, 2013, police found there were 27 children in the provider's care – far more than the allowed number of five.

After conducting a case assessment and receiving a complaint from NDP MPP Monique Taylor, the Ombudsman launched an investigation on July 15, 2013 into how the Ministry of Education (which is responsible for child care facilities) responds to complaints and concerns relating to unlicensed daycares.

In Ontario, about 78% of children are cared for in unlicensed child care arrangements. Often, these involve parents or relatives, but many are informal arrangements with unlicensed daycare operators, which are not monitored by the Ministry. For unlicensed child care, there is currently only one rule: There cannot be more than five unrelated children under age 10 in care, in addition to the provider's own children. The Ministry is supposed to follow up on complaints about violations of this rule.

The Ombudsman's assessment of what happened in Eva's case determined that the Ministry had received complaints about the daycare, but it did not follow up on them.

The evidence-gathering phase of this investigation is now complete. It included interviews with more than 25 Ministry of Education staff, as well as numerous stakeholders, and a review of all complaints the Ministry received about unlicensed daycares with more than five children between January 1, 2012 and July 2013.

The Ministry has co-operated fully with the investigation, and in December 2013, the government tabled Bill 143, the *Child Care Modernization Act*, which aimed to strengthen oversight of unlicensed daycares through increased enforcement and penalties. However, like all other pending bills, it died on the order paper when the Legislature was dissolved on May 2, 2014.

The Ombudsman expects to release his report on this investigation this summer.

Adults with developmental disabilities in crisis – Ministry of Community and Social Services

The Ombudsman has received well over **1,100** complaints in connection with this investigation, launched in November 2012, into the complex issues relating to services for adults with developmental disabilities who are in crisis situations.

Because of the high volume of complaints and the urgent nature of many of them, Ombudsman staff deal with these cases on two levels: The broad, systemic issues continue to be handled by the Special Ombudsman Response Team, while Early Resolution Officers and Investigators work with individual families and public officials to resolve their situations wherever possible.

A key theme among the complaints is the apparent lack of planning or continuity of resources and programs for children with special needs when they become adults. Families complain of long waiting lists for appropriate placements for their loved ones, particularly when they are in crisis situations – such as when young adults' behaviour becomes violent or requires specialized care that families cannot manage at home. In some cases, group homes are also unable to care for them because of a lack of resources, skills or training.

Several cases we have resolved in the past year have involved people in such situations being arrested by police and held in hospitals – often in psychiatric units – because there is nowhere else for them to go.

> "You can imagine, if you are a parent, your child turns 18, and you can't care for your child – you can't provide the support for this child you've loved all their life. What do you do then? It's extremely difficult for these parents to cope."
>
> *Ombudsman André Marin, interview with Corus radio network, February 20, 2013*

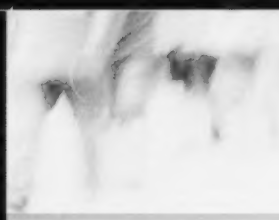
> "Housing these people in hospitals and nursing homes doesn't make sense. Many report that there is too much bureaucracy and not enough service. They feel like they are facing endless waiting lists."
>
> *Deputy Ombudsman Barbara Finlay, interview with* The National, *CBC News, March 10, 2014*

Families have also complained that the bureaucratic processes which must be navigated to access supports and services do not appear to be well equipped to deal with situations where health and safety are at issue. Many say they have experienced poor communication with developmental services organizations and assessment agencies.

The SORT investigation is focused on whether the Ministry of Community and Social Services is adequately responding to these families' situations and whether it is doing enough to co-ordinate, monitor and facilitate access to services for their loved ones.

Systemic investigation: To date, SORT investigators have conducted more than 220 interviews across the province, with adults who have developmental disabilities, their families, officials from the Ministry and Developmental Services Ontario, and other stakeholders. Tens of thousands of pages of documentation have also been obtained and reviewed.

Deputy Ombudsman Barbara Finlay is interviewed for CBC's *The National* about the Ombudsman's investigation into services for adults with developmental disabilities in crisis, March 6, 2014.



In other developments, the government's Select Committee on Developmental Services heard from families across the province about their problems in obtaining services, and issued an interim report in March 2014. The committee's final report was delayed by the dissolution of the Legislature on May 2, 2014. Similarly, the government's announcement of $810 million in new funding to assist people with developmental disabilities over the next three years was included in the May 1, 2014 budget; however, the budget – like all other pending legislation – died on the order paper when the Legislature was dissolved the next day.

The Ombudsman has begun the process of drafting his report and recommendations and hopes to release a final report in late 2014.

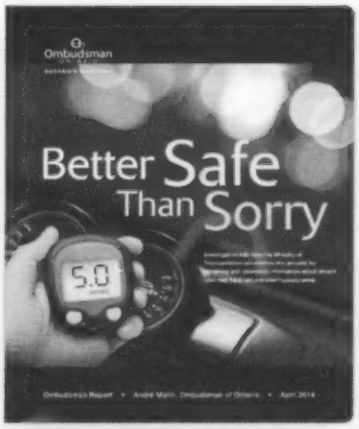
Individual cases: As the systemic investigation continues, a dedicated team of Early Resolution Officers and Investigators has helped many families navigate the complex system of assessments and requests for service, placement and funding, as well as to obtain information about waiting lists. Senior Ombudsman staff have also worked closely with regional directors and the Assistant Deputy Minister responsible for community and developmental services to flag urgent cases and recurring issues. For example:

- A developmentally disabled 63-year-old woman, who had previously been sent to a hospital psychiatric unit and specialized treatment centre because of her violent behaviour, was residing in a group home when her family contacted our Office. The group home could not provide her with the supervision she required, so she was left alone in a basement apartment for several hours each day and sent to stay with her elderly, partially blind mother two weekends per month. At one point, she was arrested and handcuffed by police for slapping group home staff. After Ombudsman staff flagged the case to the Assistant Deputy Minister, the Ministry found resources to increase the woman's supervision at the group home, and her behaviour and well-being improved.
- A young man with autism who could not communicate verbally was taken by police to a hospital after he injured respite workers. He also injured his father and was suspended from school. He was admitted repeatedly to hospital over a nine-month period when his behaviour became unmanageable. When a residential placement became available, the group home agency declined to accept him due to his behaviour. Our staff worked with the Ministry and a community agency that provided in-home support services so his father, a single parent, could continue working. He was later able to move to a specialized residential placement.

Other examples of cases where we have helped people with developmental disabilities can be found in the **Case Summaries** section of this report.

SORT INVESTIGATIONS COMPLETED IN 2013-2014

Better Safe Than Sorry – Ministry of Transportation – Monitoring drivers with uncontrolled hypoglycemia



On April 30, 2014, the Ombudsman released his report on how the Ministry of Transportation administers the process for obtaining and assessing information about drivers who may have uncontrolled hypoglycemia. This investigation stemmed from a tragic 2009 crash caused by a Hamilton driver experiencing severe uncontrolled hypoglycemia, in which three people were killed. Although the driver was immediately arrested and charged with dangerous driving causing death (and convicted in December 2011), the Ministry failed to suspend his driver's licence until January 2011.

The Ombudsman launched the investigation in March 2012, after family members of the victims asked that he investigate how the Ministry monitors drivers with potentially dangerous medical conditions.

SORT investigators conducted more than 70 interviews, including with Ministry officials, Hamilton Police Service officers, family members of the victims, and medical experts. They contacted such stakeholders as the Canadian Diabetes Association, the Nurse Practitioner Association of Ontario, the Canadian Medical Association, the Canadian Council of Motor Transport Administrators, Diabetes Education Centres and the Canadian Medical Protective Association. As well, they gathered thousands of pages of documentation and reviewed national standards and best practices from other jurisdictions.

The investigation found that a lack of co-ordination within the Ministry contributed to inordinate delay in suspending the driver's licence on medical grounds after the accident. The Ombudsman concluded that uncertainty exists about the standards the Ministry applies to assess driver safety and that the system for reporting at-risk drivers and obtaining details of medical conditions that affect driving lacks clarity and rigour.

The Ombudsman also determined that additional outreach and education efforts were needed to ensure consistent and accurate education of the public and the medical community about conditions such as uncontrolled hypoglycemia, and obligations to report them. He called on the province to raise public awareness of the potential dangers associated with some medical conditions, similar to what it has done to raise awareness of the dangers of impaired driving.

> "The potential for catastrophic accidents involving drivers with conditions such as uncontrolled hypoglycemia might have been diminished had the Ministry been more proactive in promoting and monitoring driver safety.
>
> "It is my sincere hope that implementation of my recommendations will lead to safer driving in Ontario and prevent similar devastating incidents."
>
> *Ombudsman André Marin, Better Safe Than Sorry*

Ombudsman André Marin releases his report, *Better Safe Than Sorry*, on the province's monitoring of drivers with uncontrolled hypoglycemia, April 30, 2014.

The Ministry accepted all 19 of the Ombudsman's recommendations and reported that it expects to implement most of them by September 2014. These include improvements to forms, internal training and information on its website and consulting with stakeholders on guidelines and education programs for driving responsibly with medical conditions.

On March 17, 2014, the Minister of Transportation introduced Bill 173, which would have amended the *Highway Traffic Act* and addressed some of the Ombudsman's recommendations with regard to reporting drivers with certain medical conditions. However, this bill died on the order paper when the Legislature was dissolved on May 2, 2014.

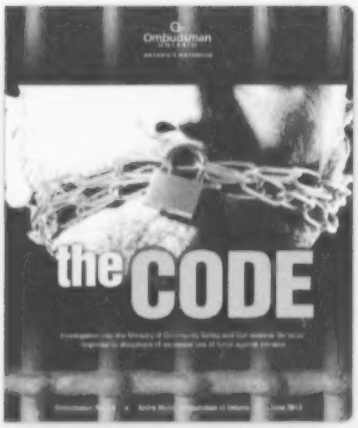
The Ombudsman was pleased with the Ministry's positive response to his report and the efforts it has already made towards implementation of his recommendations. The Ministry has committed to providing the Ombudsman with updates on its progress every six months.

> "The Ombudsman has provided a clear-eyed systemic review of the circumstances and a series of recommendations which will make a real difference. I am very pleased and grateful for the way in which [the Ombudsman's Office] did their work, for the kindness with which they conducted it, and I am grateful that the Ministry has accepted the recommendations. Moving forward from here, we will all be able to say that we're living in a safer province."
>
> *Rupert Gordon, brother of accident victim Hannah Gordon-Roche, April 30, 2014*

> "The CDA looks forward to continuing to work with the government and the Ombudsman's Office to address the issues raised in the report and to ensure that Ontario has a fair and safe vehicle and driver licensing system."
>
> *Statement by Canadian Diabetes Association, April 30, 2014*

UPDATES ON PREVIOUS SORT INVESTIGATIONS

The Code – Ministry of Community Safety and Correctional Services



In June 2013, the Ombudsman released *The Code*, his report on how the Ministry of Community Safety and Correctional Services deals with allegations of excessive use of force by correctional officers. The report called on the Ministry to eliminate the dysfunctional culture and pervasive "code of silence" that allowed some correctional staff to cover up aggressive, violent acts against inmates.

The report was the result of more than 180 interviews with inmates, Ministry officials at all levels, stakeholder groups and whistleblowers. Investigators also reviewed thousands of pages of documentation.

The Ministry agreed to all **45** of the Ombudsman's recommendations, including several specifically addressing the code of silence and the need to create clearer procedures for reporting and investigating incidents of excessive use of force. It also committed to reporting to the Ombudsman on its progress every six months.

The Ministry began providing the Ombudsman with informal updates within weeks of the report's release. In its first official report, in December 2013, it outlined several significant measures it has taken, including:

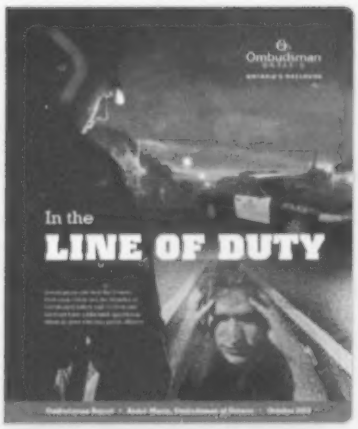
- Issuing a memorandum to all correctional staff from the Deputy Minister of Correctional Services, declaring that upholding the code of silence would be grounds for discipline, including termination (this marked the first time the code of silence was specifically acknowledged by the Ministry);
- Ensuring all code of silence allegations are dealt with at the Ministry's highest levels, involving its internal investigations unit and police where necessary;
- Requiring immediate reporting of incidents where the code of silence is a factor, and notification of the Deputy Minister of all incidents and investigation outcomes;
- Updating internal employee policies to include statements expressly prohibiting activities that support the code of silence;
- Drafting a new code of conduct and ethics for correctional staff;
- Implementing new penalties for workers who uphold the code of silence, and assistance for those who have been victimized by it;
- Addressing the code of silence and the appropriate use of force during new recruit training;
- Restructuring to create the Correctional Services Oversight and Investigations Branch, headed by a Chief of Oversight and Investigations, who reports directly to the Deputy Minster; and
- Introducing Risk Management Teams in every institution, to assess whether force is used according to policy and recommend discipline when appropriate.

To date, the Ministry has addressed **34** of the Ombudsman's **45** recommendations and is working on the rest, including plans to upgrade closed-circuit camera surveillance systems in correctional facilities.

Ombudsman staff continue to monitor complaints received about the use of excessive force against inmates. These increased slightly in the past year, from 67 in 2012-2013 to **71** in 2013-2014. In each case, Ombudsman staff review the facility's response to ensure that the Ministry's new policies are being followed. The Ministry will continue to report to the Ombudsman every six months on its progress.

> "Subject: The Code of Silence
>
> As malicious peer pressure undermines a healthy and safe work environment, these actions and behaviours are unacceptable and will not be tolerated.
>
> Individuals who engage in Code of Silence and reprisal-related conduct will be held accountable for their actions and will be subject to appropriate discipline, up to and including termination from employment."
>
> *Excerpt from memorandum to all correctional services staff, from Stephen Rhodes, Deputy Minister of Correctional Services, August 16, 2013*

In the Line of Duty – Ontario Provincial Police and Ministry of Community Safety and Correctional Services



In October 2012, the Ombudsman released *In the Line of Duty*, his report on how the Ontario Provincial Police and the Ministry of Community Safety and Correctional Services were dealing with operational stress injuries affecting police officers. Operational stress injuries include conditions such as depression, addictions, anxiety, and post-traumatic stress disorder.

During the investigation, the Ombudsman received complaints from **111** active and retired OPP and municipal officers and their families. He found that both the OPP and the Ministry were reluctant to acknowledge and tackle operational stress injuries among police, and that a "suck it up" attitude persisted towards officers who were suffering. The lack of support services, training and education for OPP members was a dominant issue. The investigation also revealed that more active and retired OPP officers had committed suicide since 1989 than had been killed by an assailant in the line of duty – yet the OPP did not officially track or review suicide cases.

The Ombudsman's report focused on the need to confront the stigma of operational stress injuries in police culture. He made **28** recommendations to the OPP and **six** to the Ministry, including implementing comprehensive OPP education and training programs as well as a suicide prevention program, improving employee assistance programs, collecting data on operational stress injuries and police suicides, and developing provincial standards for police services to address these issues.

The OPP has provided the Ombudsman with quarterly updates on its steps to implement his recommendations. (These updates can be found on the OPP's website.) To date, these include:

- Seven permanent, full-time positions for leaders of Critical Incident Stress Response Teams, which provide peer support for OPP officers;
- Training external clinicians to become familiar with OPP culture and support programs;
- Informal lunch-and-learn sessions for officers on mental health awareness;
- A pilot workshop called "Courageous Conversations" for OPP supervisors on how to recognize early signs of operational stress injury; and
- Meeting with regional Ontario police services to exchange ideas on how to address operational stress injuries.

As for the Ministry, in its quarterly updates, it has committed to develop a province-wide confidential survey to assess how many active and retired officers across the province have operational stress injuries.

The Ministry is also:

- Working with the Office of the Chief Coroner to identify officer and retired officer suicides;
- Creating a new position for a "Resiliency and Wellness Instructor" at the Ontario Police College;
- Co-ordinating information sharing with police services across the province to address operational stress injuries and suicide prevention; and
- Engaging in research to develop provincewide standards for police services and police services boards on operational stress injuries.

The Ombudsman is pleased with the progress to date by the OPP and the Ministry in responding to the report's recommendations, and noted there appears to be a genuine commitment on the OPP's part to tackle the problems exposed in the investigation.

Non-emergency medical transportation services – Ministry of Health and Long-Term Care, Ministry of Transportation

In last year's Annual Report, the Ombudsman highlighted several pieces of "unfinished business" – where government commitments to implement recommendations were not fulfilled. One such commitment involved the Ombudsman's investigation – launched in January 2011 – into non-emergency medical transportation services. The investigation focused on whether the Ministry of Transportation and Ministry of Health and Long-Term Care were adequately protecting the hundreds of thousands of patients who use these unregulated vehicles (which often look like ambulances but are not) every year.

The Ombudsman's investigation found serious issues, such as poorly maintained vehicles, untrained staff, lack of equipment and no mechanism to take or resolve complaints from the public. In May 2011, the Ombudsman shared his findings with the two Ministries, and in June that year, the then-ministers (Deb Matthews – Health, and Kathleen Wynne – Transportation), jointly announced new legislation to regulate the industry, although their announcement came after the Legislature had risen for the summer, prior to the fall 2011 election.

With the issue apparently resolved, the Ombudsman opted not to publish a report. The Ministry of Health and Long-Term Care began creating a regulatory framework and consulting with industry stakeholders, but progress was slow. Legislation was finally introduced in December 2013 to establish standards for "stretcher transportation services," as part of Bill 151, the *Strengthening and Improving Government Act, 2014.*

The legislation would have regulated the industry, requiring the Ministry of Transportation to licence all providers and conduct routine vehicle inspections. It also would have prohibited use of the word "ambulance" on non-emergency transport vehicles. However, like all other pending legislation, it died when the Legislature was dissolved on May 2, 2014 prior to the June 12, 2014 election.

The Ombudsman is concerned that the move to make this industry safer has been halted, some three years after his initial investigation. At time of printing this report, the issue continues to be a piece of unfinished business, and the Ombudsman will follow up on it in the next legislative session.

Oversight Undermined and *Oversight Unseen* – Ministry of the Attorney General and Special Investigations Unit

The Ombudsman has conducted two systemic investigations and released two reports about the Special Investigations Unit (SIU), the agency that investigates police involvement in incidents of serious injury or death. The first report, *Oversight Unseen* (2008), called for legislation to give the agency more teeth and ensure more rigour in its investigations; the second, *Oversight Undermined* (2011), again called for stronger legislation and called on the Ministry of the Attorney General to support the SIU in holding police services to account.

Both reports identified issues that continue to pose challenges for the SIU, and the Ombudsman continues to follow up on developments relating to these issues, including problems with police meeting their obligation to co-operate with the SIU, lawyers vetting the notes of officers involved in SIU investigations, and the lack of a clear legal definition of "serious injury."

In *Oversight Undermined,* the Ombudsman stressed that "given the need to instill public confidence in the system of civilian oversight of police," it is essential that officers involved in SIU investigations prepare their notes "promptly and independently without the influence of counsel."

The Ombudsman's position echoed that of a November 2011 ruling of the Ontario Court of Appeal, which was subsequently appealed to the Supreme Court of Canada. In December 2013, the Supreme Court also supported this view, noting that the SIU was established as "an independent and transparent investigative body for the purpose of maintaining public confidence in the police and the justice system as a whole."

In the decision, Supreme Court Justice Michael Moldaver wrote:

> "Permitting police officers to consult with counsel before their notes are prepared is an anathema to the very transparency that the legislative scheme aims to promote. Put simply, appearances matter. And, when the community's trust in the police is at stake, it is imperative that the investigatory process be – and appear to be – transparent."

The Supreme Court's decision capped a long legal journey by the families of two men shot dead by OPP officers in two incidents in 2009, Levi Schaeffer and Douglas Minty. In both cases, lawyers for the officers present vetted their notes before they were given to the SIU.

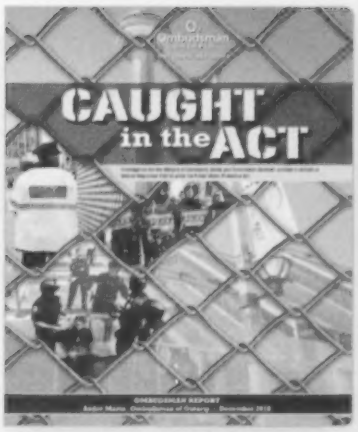
In other developments, Ian Scott, who was appointed SIU Director immediately after 2008's *Oversight Unseen* and whose efforts to improve transparency and accountability in the face of resistance from police and the Ministry were detailed in *Oversight Undermined,* ended his term in the fall of 2013. "There was pressure put on me to not bring light to some of these issues," he told the *Toronto Star* in September 2013, stressing that a strong police oversight body benefits police and the public alike.

The Ombudsman continues to monitor issues and complaints relating to the SIU, including dealing with **13** new complaints and submissions this year, on issues ranging from alleged failure to provide information to allegations of bias in an investigation.

> "If police have to write their own notes and are not assisted by a lawyer, and their notes are not enhanced by a lawyer, then the next mother of somebody who's been shot by police will know what happened. I will never know what happened to my son."
>
> *Ruth Schaeffer, mother of police shooting victim Levi Schaeffer, quoted in the* Toronto Star, *December 19, 2013.*

> "I am confident that the clarity the [Supreme Court of Canada] has brought to this contentious issue will be of benefit to all parties involved in SIU investigations. It will without question contribute, as the Court suggests, 'to maintaining public confidence in the police and the justice system as a whole.'"
>
> *SIU Director Tony Loparco, quoted in the* Toronto Star, *December 19, 2013.*

Caught in the Act – Ministry of Community Safety and Correctional Services



Four years after Toronto played host to the G20 summit in June 2010, the Ombudsman continues to monitor the government's progress in responding to *Caught in the Act*, his 2010 report revealing the Ministry of Community Safety and Correctional Services' role in expanding police powers during the summit.

The report detailed how the Ministry agreed, without informing the public, to a Toronto Police request to invoke a little-known World War II-era statute, the *Public Works Protection Act (PWPA)*, enabling police to detain and search hundreds of protesters and bystanders.

In his report, the Ombudsman recommended that the *PWPA* be repealed or replaced so the mass violations of civil liberties that occurred during the G20 wouldn't be repeated. The Ministry agreed. However, legislation to fulfill this promise has twice been derailed when legislative sessions ended – first in October 2012 and again in May 2014.

The most recent attempt to address the issue came with the introduction of Bill 51, the *Security for Courts, Electricity Generating Facilities and Nuclear Facilities Act, 2014*, introduced on April 10, 2013. The bill sought to repeal the *PWPA* while providing for the security of courts, electricity generating facilities and nuclear facilities. However, debate on its second reading began on April 24, 2013 but did not resume until April 30, 2014, and it died along with all other pending legislation when the Legislature was dissolved on May 2, 2014.

Although representatives from all parties have acknowledged the need to address the *PWPA* – for example, then-Minister of Community Safety and Correctional Services Madeleine Meilleur described it as "outdated" and "unnecessary" – it remains in force. The Ombudsman remains concerned about this unfinished business and will monitor developments closely in the next session of the Legislature, especially as Toronto prepares to host another large public event – the 2015 Pan Am and Parapan Am Games.

> "The Ombudsman, Monsieur André Marin, produced a report that raised important questions about how the *[Public Works Protection Act]* works and how it was used during the G20."
>
> *Minister of Community Safety and Correctional Services, Madeleine Meilleur, Hansard, April 24, 2013*

Monitoring of long-term care homes – Ministry of Health and Long-Term Care

Although the Ombudsman does not have jurisdiction over long-term care homes – they are part of the so-called "MUSH" sector, detailed in the section of this report entitled "**Beyond Scrutiny: MUSH Sector Complaints**" – our Office is able to investigate how the Ministry of Health and Long-Term Care monitors them.

In December 2010, the Ombudsman released the findings of an investigation, launched in 2008, into complaints about the monitoring and inspection system for long-term care. Among the systemic problems he identified were inconsistent application of standards, lack of frequent inspections, and inadequate public reporting. Although he opted not to publish a full report at that time because the Ministry of Health and Long-Term Care was taking the problems seriously and the monitoring system was a "work in progress," SORT has closely monitored the Ministry's actions in this area ever since.

The Ministry now has a new inspection regime, and announced in June 2013 that it was hiring 100 additional inspectors. As of February 2014, 88 inspectors had been hired and were being trained. The Ministry's goal is to have the capacity to conduct proactive, annual "resident quality inspections" in every long-term care home in the province by the end of 2014.

In 2013-2014, the Ombudsman received **20** complaints about the Ministry's Performance Improvement and Compliance Branch, which handles long-term care home inspections. These included concerns about delayed inspections, the quality of inspections and a lack of follow-up by the Ministry in cases of non-compliance.

In early 2014, SORT investigators conducted a new review of this issue, spurred in part by a complaint from NDP MPP France Gélinas that many facilities might not be complying with orders from Ministry inspectors. The review included interviewing senior Ministry staff, obtaining statistics on long-term care inspections, and gathering information about the hiring and training programs for new inspectors.

SORT staff identified several areas for improvement, including the timeliness of inspections and the methods for collecting and assessing follow-up inspection data. Based on our observations, which we shared with senior Ministry officials, the Ministry is following up with regional offices to make changes.

The Ombudsman determined that given recent changes – including the addition of a significant number of inspectors, new measures to improve inspections and the Ministry's commitment to conduct more proactive and comprehensive inspections – it would be premature to launch a new formal investigation. Our Office will continue to review the regular updates we receive from the Ministry to assess whether or not a systemic investigation is warranted.

Too Cool for School and *Too Cool for School Too* – Private career colleges and colleges of applied arts and technology

The Ombudsman released two reports in 2009 on systemic investigations into the Ministry of Training, Colleges and Universities' oversight of private career colleges and colleges of applied arts and technology – entitled, respectively, *Too Cool for School* and *Too Cool for School Too*. Although the specific circumstances involved in those investigations were resolved – relating to Bestech Academy near Hamilton and Cambrian College in Sudbury – we continue to receive new complaints about similar issues.

The Ministry's Private Career Colleges Branch has oversight of all registered private career colleges in Ontario and is also responsible for enforcement action against unregistered private career colleges. We received **15** complaints from private career college students and operators in 2013-2014 (down slightly from last year's 19).

In one case, reminiscent of the case detailed in *Too Cool for School*, a student complained about a lack of information from the Ministry about what to do when the private career college she was attending suddenly shut down. We contacted the Ministry and provided the student with the information she needed to apply for a tuition refund.

We also received **100** complaints about colleges of applied arts and technology, which are funded by the Ministry and are expected to ensure students graduating from their programs have skills that meet set standards.

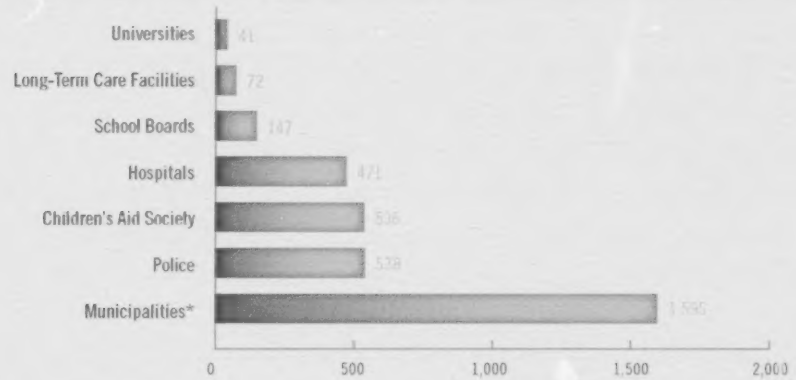
In a case similar to that featured in *Too Cool for School Too*, students in a heating, refrigeration and air conditioning program complained that the program was not certified by the Technical Standards and Safety Authority (TSSA), and without that certification, their job prospects would be limited upon graduation.

Ombudsman staff are reviewing the Ministry's role in approving such programs and what steps it has taken to respond to the Ombudsman's recommendations since his 2009 report. At that time, the Ombudsman said the Ministry had "abdicated" its responsibility to ensure college programs met its standards, and called its response to his report "disappointing."

Beyond Scrutiny: MUSH Sector Complaints

The Ombudsman received a record **3,400** complaints and inquiries in 2013-2014 about organizations in the **MUSH** sector – **m**unicipalities, **u**niversities, **s**chool boards and **h**ospitals, as well as long-term care homes, children's aid societies and police. This represents a **34%** increase over last year's previous record of 2,541. The growing demand for oversight of these organizations is not surprising, since their services affect Ontario's citizens profoundly. Unfortunately, Ontario remains the only province in Canada whose ombudsman has no oversight of any MUSH organizations.

MUSH SECTOR CASES
RECEIVED DURING FISCAL YEAR 2013-2014 TOTAL: 3,400



*Excludes cases received about closed municipal meetings.

DEAD LAST
How the Ontario Ombudsman's mandate compares to others in key areas of jurisdiction

	MUNICIPALITIES	UNIVERSITIES	SCHOOL BOARDS	PUBLIC HOSPITALS	LONG-TERM CARE HOMES	CHILD PROTECTION SERVICES	POLICE COMPLAINTS REVIEW MECHANISM
ONTARIO	NO	NO	NO	NO	NO	NO	NO
British Columbia	Yes	Yes	Yes	Yes	Yes	Yes	No
Alberta	No	No	No	Yes	Yes	Yes	Yes
Saskatchewan	No	No	No	Yes	Yes	Yes	Yes
Manitoba	Yes	No	No	Yes	Yes	Yes	Yes
Quebec	No	No	No	Yes	Yes	Yes	Yes
New Brunswick	Yes	No	Yes	Yes	Yes	Yes	Yes
Newfoundland and Labrador	No	Yes	Yes	Yes	Yes	Yes	Yes
Nova Scotia	Yes	No	Yes	Yes	Yes	Yes	Yes
Yukon	Yes	No	Yes	Yes	Yes	Yes	No

Efforts to change this date back to the very first days of this Office. The first Ontario Ombudsman, Arthur Maloney, argued forcefully for the Office's mandate to be extended to the broader public sector, and after he left office, he issued an extensive "blueprint" report documenting his arguments on **March 29, 1979**. Almost 35 years later to the day, on **March 24, 2014**, the first government bill to propose such changes was introduced by Government Services Minister John Milloy.

Among many other broad accountability measures, **Bill 179** – the *Public Sector and MPP Accountability and Transparency Act, 2014* – would have opened the MUSH sector to independent oversight for the first time. It proposed to give the Ombudsman oversight of municipalities, universities and school boards, while creating a "Patient Ombudsman" for hospitals and long-term care, and expanding the powers of the Provincial Advocate for Children and Youth to include investigations of children's aid societies.

Although Bill 179 died on the order paper when the Legislative Assembly was dissolved on May 2, 2014 – meaning it will not go forward unless it is reintroduced in some form in a future legislative session – we have included an explanation here, for the record, of how it proposed to affect the Ombudsman's mandate in each MUSH sector area. The bill can also be read on the Legislative Assembly's website, **www.ontla.on.ca**, under "Bills and Lawmaking."

Even had the bill passed, however, Ontario would have remained "dead last" in ombudsman oversight of MUSH organizations, as the accompanying provincial comparison chart shows. As of June 1, 2014, when New Brunswick's ombudsman gained authority over long-term care homes, Ontario is alone in Canada in barring ombudsman oversight of hospitals, long-term care and child protection. And while ombudsman mandates vary in the other MUSH areas, all have oversight of more than three.

There were **34** petitions tabled in the Legislature in support of extending the Ombudsman's mandate to MUSH bodies in 2013-2014, bringing the total since 2005 to **131**. Members of Provincial Parliament also introduced **three** private member's bills to give the Ombudsman jurisdiction over various areas of MUSH this year, a total of **18** since 2005. Only one – Bill 42, the *Ombudsman Amendment Act (Children's Aid Societies), 2013*, introduced by NDP MPP Monique Taylor – made it past second reading. It was referred to the Standing Committee on Government Agencies in April 2013, but died on the order paper with all other pending legislation on May 2, 2014.

Our Office assists people who complain to us about MUSH organizations by referring them to help where possible. We also track the issues raised and summarize them each year in this report to raise awareness of the need for increased oversight.

> "A hard-biting watchdog with a knack for drawing public attention to problems and mistakes in the province, Mr. Marin has long been a thorn in the side of the government, which may help explain why Queen's Park has often been reluctant to grant him more latitude. But giving him the right to look into municipalities and local agencies, in particular, will represent a massive expansion of his role, allowing him into a whole new level of government. Most municipalities in Ontario do not have independent watchdogs of their own, meaning the new rules will expose them to an unprecedented level of scrutiny."
>
> *Adrian Morrow, Globe and Mail, March 6, 2014*

"M" – MUNICIPALITIES

The Ombudsman's jurisdiction over municipalities is limited to investigating complaints about closed meetings. Our Office is the closed meeting investigator for all municipalities that have not appointed their own – a total of **195** municipalities across the province as of March 31, 2014.

However, we continue to receive more complaints about municipalities than any other area of the MUSH sector. We received (and were obliged to turn away) **1,595** cases in 2013-2014, a substantial increase (**48%**) partly due to widespread public concern about billing and customer service problems relating to local hydro utilities. (The Ombudsman launched a systemic investigation in February 2014 into these types of issues at the provincially-run Hydro One, but does not have the authority to investigate municipal utilities.)

Citizens also raised a variety of other municipal issues, including living conditions and unfair evictions in public housing, the calculation and collection of property taxes, the adequacy of by-law enforcement, zoning and building permit practices, excessive licence fees and building development charges, municipal expropriations, and the conduct of council members, including conflicts of interest.

Although all of Ontario's 444 municipalities have the power to create their own accountability offices, the City of Toronto remains the only one to have its own Ombudsman (which it was required to establish under the *City of Toronto Act*). Citizens elsewhere have nowhere to turn for independent investigative scrutiny of municipal concerns.

Bill 179 would have given Ontario's Ombudsman broad authority to investigate municipal concerns, once any existing local complaint and appeal mechanisms had been exhausted. This would have included the ability to review, if warranted, the work of other closed meeting investigators and municipal accountability offices such as local ombudsmen. In 2013-2014, we received **12** complaints about how cases were handled by the Toronto Ombudsman.

"U" – UNIVERSITIES

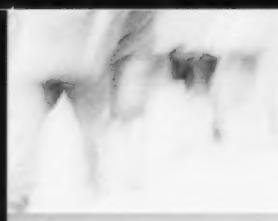
Although our Office can and does investigate complaints about Ontario's colleges of applied arts and technology, universities are immune from our scrutiny because of their governance structure (a discrepancy that would have been addressed by Bill 179). In **2013-2014**, we received **41** complaints and inquiries about universities.

Students sought our help for a range of issues, from internal appeal and complaint processes to accommodations for students with special needs, to financial administration of student accounts.

"S" – SCHOOL BOARDS

We received **147** complaints and inquiries about Ontario school boards in 2013-2014, including concerns about student discipline, inadequate special education supports, limited complaint processes, insufficient response to bullying, illegal closed school board meetings, and poor communication. Bill 179 would have extended the Ombudsman's oversight to school boards.

Under supervision: The Ombudsman does have temporary jurisdiction over school boards when the Ministry of Education appoints supervisors to take control



of them. In 2013-2014, Windsor-Essex Catholic District School Board was under the supervision of a Ministry-appointed supervisor until November 27, 2013. We received **four** complaints about this board, raising issues about accountability, response to complaints, and employment-related matters. We made regular inquiries with the supervisor to monitor the board's progress in responding to these concerns and implementing administrative improvements.

"H" – HOSPITALS

Complaints about hospitals also increased in 2013-2014, to **471** from 369 the previous year. These included such issues as inadequate patient care, poor infection control, faulty record keeping and breaches of patient confidentiality. We also received complaints about the ineffectiveness of internal "patient relations" and "patient advocate" (sometimes called "patient ombudsman") processes at Ontario's hospitals. Although we were unable to investigate these complaints, we referred people to help wherever possible.

Bill 179 did not propose extending the Ontario Ombudsman's jurisdiction to hospitals, but instead would have created a new "Patient Ombudsman." However, our Office would have had the authority to investigate complaints about the Patient Ombudsman.

Under supervision: The Ombudsman has temporary jurisdiction over hospitals when the Ministry takes direct control via the appointment of supervisors. The Niagara Health System was under supervision until January 10, 2014 and was the subject of **15** complaints to our Office in 2013-2014 (down from 31 and 81 complaints in the two previous years). These included concerns about fiscal accountability and lack of services, which were resolved through the supervisor. The province also appointed a supervisor for Anson General Hospital in August 2013 in the wake of several high-profile departures and public demonstrations. We received four complaints about this hospital in 2013-2014 relating to patient care, which were assessed and followed up with the supervisor where necessary.

LONG-TERM CARE HOMES

Patients, family members, and some staff of Ontario's long-term care homes approached us with **72** complaints in 2013-2014, relating to poor resident care, lack of security policies, and inadequate record keeping and billing practices. We provided referrals to other resources where appropriate.

As with hospitals, the Patient Ombudsman proposed by Bill 179 would have had the authority to deal with complaints about long-term care homes. Our Office would have had jurisdiction to consider the adequacy of the Patient Ombudsman's response to such complaints.

Investigation update: While we cannot investigate long-term care homes directly, we continue to follow up on our investigation into how the Ministry of Health and Long-Term Care monitors them. Details about this can be found in the **Special Ombudsman Response Team** section of this report.

CHILDREN'S AID SOCIETIES

In **2013-2014**, the Ombudsman received **536** complaints and inquiries about children's aid societies (CASs) across Ontario. We heard from youth in care, former Crown wards, parents, grandparents and foster parents. Concerns were raised about delayed, inadequate and biased investigations, problematic child apprehensions, failure to respond to complaints, poor communication, and denial of access to children in care.

We also received **nine** complaints about the Child and Family Services Review Board, some expressing dissatisfaction with its restricted jurisdiction. Although the board oversees CASs, its narrow mandate allows it to consider only procedural concerns about children's aid societies filed by individuals actually "seeking or receiving services" from them. It is also limited to granting procedural remedies, such as ordering that a CAS respond or provide reasons.

Bill 179 would not have given the Ontario Ombudsman authority over CASs. However, it would have expanded the authority of the Provincial Advocate for Children and Youth – an Officer of the Legislature like the Ombudsman – to include investigating and reporting on concerns about CASs.

POLICE

This year, the Ombudsman received **538** complaints and inquiries about police, a 46% increase over the previous year. Some of these involved concerns about the actions of Toronto Police in connection with the shooting of 18-year-old Sammy Yatim in July 2013. (Although our Office does not have jurisdiction over local police, the **Special Ombudsman Response Team** is conducting a systemic investigation into the direction provided to police by the Ministry of Community Safety and Correctional Services for de-escalating conflict situations.)

Ontarians also raised a host of other issues with policing, including allegations of assault, harassment, racial profiling, inappropriate treatment of individuals with special needs and/or suffering from mental illness, property damage, inadequate enforcement, and insufficient response to police misconduct. These complaints were referred to the Ministry of the Attorney General's Office of the Independent Police Review Director (OIPRD) or the Special Investigations Unit (SIU).

In **2013-2014**, we received **36** complaints and inquiries about the Office of the Independent Police Review Director, which, unlike the SIU, is excluded from the Ombudsman's mandate. Complaints ran the gamut from lack of response during the intake process, to failure to investigate officers, to questions about the OIPRD's independence.

Training and Consultation

Since 2007, the Office of the Ombudsman has shared its expertise in systemic investigation and complaint resolution techniques with other watchdog agencies around the world. The Ombudsman's training course, "Sharpening Your Teeth: Advanced Investigative Training for Administrative Watchdogs," is delivered each year in Toronto and elsewhere upon request, always on a complete cost-recovery basis. The Ombudsman and senior staff are also frequently asked to consult with agencies in the oversight field.

TRAINING

In November 2013, the Ombudsman and two senior staff delivered "Sharpening Your Teeth/Aiguisez-vous les dents" training in back-to-back courses in English and French for the first time. The sessions were hosted in Lusaka, Zambia by the International Ombudsman Institute, the African Ombudsman Research Centre and the Commission for Investigations in Zambia (Zambia's Ombudsman). More than 80 people from 20 countries attended, representing dozens of ombudsmen, mediators and "watchdog" agencies.

Countries represented at the training included: Benin, Burkina Faso, Burundi, Chad, Djibouti, Ethiopia, Gabon, Gambia, Ivory Coast, Kenya, Lesotho, Niger, Nigeria, Sierra Leone, South Africa, Sudan, Tanzania, Tunisia, Uganda and Zambia. The ombudsmen of Botswana, Burkina Faso, Kenya, Namibia, South Africa and Kenya were also in attendance.

> "When you work in an ombudsman office, your teeth can sometimes get blunt. Training like this reminds us that we need to review our practices and sharpen our teeth. A watchdog without teeth is not very good security."
>
> *Caroline Sokoni, Ombudsman of Zambia*

> "All Ombudsmen in Africa are indebted … to Ontario Ombudsman André Marin for his willingness to help us sharpen our teeth."
>
> *John Walters, Ombudsman of Namibia*

> "The African continent is one – we have broken the language barrier and we are convinced that this training will not end here. Mr. Marin's program will be very useful to us when we handle recurring problems."
>
> *Alima Traoré, Ombudsman (Médiateur) of Burkina Faso*

Lusaka, Zambia was the site of back to back French and English sessions of "Sharpening Your Teeth" training in November 2013, delivered by Ontario Ombudsman André Marin, along with Senior Counsel Wendy Ray and Communications Director Linda Williamson. Sponsored by the International Ombudsman Institute, the course drew participants from 20 countries across Africa.

The Ombudsman and staff were also invited to conduct customized versions of the course in May 2013 for the Caribbean Ombudsman Association's biennial conference in Sint Maarten, and in April 2013 for staff of Ontario's Independent Electricity System Operator in Oakville.

The most recent Toronto session of Sharpening Your Teeth (SYT), held January 20-22, 2014, welcomed some 70 participants, including several high-level Ontario public servants, as well as representatives of the Alberta Public Interest Commissioner's office, the Commission for Public Complaints Against the RCMP, and the Ombudsman for Children in Dublin, Ireland.

A video of SYT highlights is available on our YouTube channel, www.youtube.com/ontarioombudsman.

Participants at SYT Toronto in January 2014 learn about investigation techniques from SORT Director Gareth Jones (top right), Director of Investigations Sue Haslam (top left), and Senior Counsel Wendy Ray (standing, bottom).

Comments from SYT participants, January 2014

> "Superb course! Very professionally presented. I feel fortunate to have been able to participate."
>
> *Glen Archambault, Ministry of Children and Youth Services*

> "An innovative approach, proven results. Thanks for sharing insight."
>
> *Jim Aspevis, Ministry of Community Safety and Correctional Services*

> "Very practical. I enjoyed hearing about real investigations as well as use of case studies. Very well organized and great speakers."
>
> *Emily Musing, Death Investigation Oversight Council*

> "Your course provided new information and a good insight into what the Ombudsman's Office is all about. Thank you for a great three days."
>
> *Norm Walker, Ministry of Community Safety and Correctional Services*

> "Great training. Well presented. Very professional."
>
> *Daniel Berthiaume, Department of National Defence*

> "Excellent. Great dissemination of information, case studies, images and group exercises. Presenters were all very engaging and knowledgeable."
>
> *Alison Stewart, Office of the French Language Services Commissioner of Ontario*

> "Thanks to @Ont_Ombudsman and all of the staff for a great course. Highly recommend it. Learned lots and met great people."
>
> *@2ndcareer527 via Twitter*

A visiting municipal official from the Changning district of Shanghai, China takes a photo on his iPad during a presentation by Ombudsman André Marin, August 2013

CONSULTATION WITH OTHER AGENCIES

Among those who visited our Office in 2013-2014 to learn about our oversight role were delegations from Changning, a district of Shanghai, China (August 2013) and Vietnam (October 2013). The Ombudsman and senior staff were also invited to consult with, among others, staff from the Wildlife Enforcement and Environmental Enforcement divisions of Environment Canada, and the Office of the French Language Services Commissioner of Ontario.

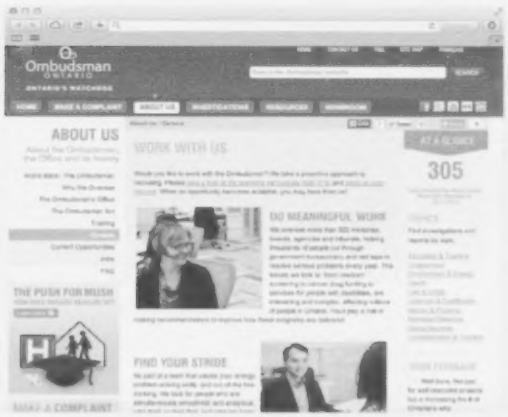
As well, senior Ombudsman staff gave numerous presentations on our Office's role and work to representatives of Ontario ministries, agencies and interest groups, including the Prosecutors' Association of Ontario, the Council of Canadian Administrative Tribunals, the Workplace Safety and Insurance Appeals Tribunal, the Society of Ontario Adjudicators and Regulators, the Elizabeth Fry Society, and the Association of Municipal Managers, Clerks and Treasurers of Ontario.

In May 2014, our Office hosted the annual meeting of the **Canadian Council of Parliamentary Ombudsman**, where the Ombudsman and his counterparts from across the country discussed common issues and best practices. The group also discussed strategies for dealing with high volumes of complaints as well as oversight of areas of the MUSH sector.

The Ontario Ombudsman's Office hosted the 2014 annual meeting of the Canadian Council of Parliamentary Ombudsman, May 2014. From left: New Brunswick Ombudsman Charles Murray, Saskatchewan Ombudsman Mary McFadyen, Newfoundland and Labrador Citizen's Representative Barry Fleming, Ontario Ombudsman André Marin, Quebec Protecteur du citoyen Raymonde Saint-Germain, British Columbia Ombudsperson Kim Carter, Nova Scotia Acting Ombudsman Christine Delisle-Brennan, and Yukon Ombudsman Diane McLeod-McKay.

Communications and Outreach

Communication with the public is essential to the Ombudsman's role. Our Office uses media and technology wherever possible to engage and inform Ontarians – and to ensure public appearances and press conferences by the Ombudsman and his senior team reach a wide audience.



COMMUNICATIONS

In 2013-2014, as public complaints to our Office reached an all-time high, media coverage, website traffic and social media interaction all did likewise.

Traditional media

There were **1,205** print articles about the Ombudsman's Office in 2013-2014, primarily in daily newspapers across Ontario and the rest of Canada. The estimated advertising value of these articles was **$3.1 million**, reaching an aggregate audience of **77.8 million people**, according to calculations by Infomart, based on newspaper advertising rates, circulation and page display. This represents an increase of 48% in audience reach, and 41% in ad value over 2012-2013.

There were also **1,203** news items about the Ombudsman and our work broadcast on radio and television in Ontario and across Canada – a 36% increase over the previous year.

Ombudsman André Marin was also honoured by two magazines in 2013-2014, as part of their "Most Influential" lists.

In August 2013, he was named one of the top 25 most influential lawyers in Canada by *Canadian Lawyer*. Voters in the magazine's survey referred to the Ombudsman as "the voice of reason, logic, justice and of our society's most marginalized citizens," as well as "courageous, tenacious, principled, innovative."

In September 2013, *Toronto Life* chose him as one of its 50 most influential people in Toronto, noting that "to his fans," the Ombudsman is "a tireless advocate for transparent, effective government and a champion of the so-called little guy."

Social media

The Ombudsman's **Twitter** account (**@Ont_Ombudsman**) reached more than **20,000** followers as of March 31, 2014, and continues to grow. The Ombudsman tweets personally on this account unless otherwise noted, and uses Twitter to inform the public, share information about our Office, our work, and news of interest in the oversight field (for example, involving the MUSH sector). Events such as press conferences and speeches are also live-tweeted on the Ombudsman's account with the hashtag #OOLive.

Our Office's following on Facebook (**2,894** likes) and YouTube (**26,100** views) also increased in 2013-2014. The most popular YouTube video was the Ombudsman's announcement of his Hydro One investigation, which had **950** views as of March 31, 2014. The Ombudsman also began using **ScribbleLive** to conduct live question-and-answer sessions after the release of the 2012-2013 Annual Report and OMLET Annual Report – these sessions are archived on our website.

> "Congratulations. Your office's use of #socialmedia is an example for open and responsive government to follow."
> *@BorjeMelin via Twitter*

> "I like having the Ombudsman on Twitter. One could argue it makes the office more accessible."
> *@MikeCBC via Twitter*

> "I must say, you and your office use Twitter very well. It makes a lot of sense for the Ombudsman to be active on social media."
> *@AbdiAidid via Twitter*

> "Please do continue the great work via social media. The transparency is a great relief."
> *@Mediacation1 via Twitter*

> "I never thought about your office until Twitter. Thank you for doing this!"
> *@dkane_argyle via Twitter*

Website and mobile app

The Ombudsman's website, **www.ombudsman.on.ca**, is a one-stop resource for anyone who needs to file a complaint, access the Ombudsman's reports and videos, find news and information about our Office, or contact us through social media. Unique visitors to the website increased by 25% in 2013-2014, to 125,593. There were **185,758** total visits and **778, 283** pageviews, according to Google Analytics. Visitors came to the site from **179** countries.

There was also a sharp increase in visits to the mobile-optimized version of the Ombudsman's website, or "mobile app," which can be accessed via smartphone or tablet. The mobile site had **32,167** unique visitors – an increase of 126% over the previous year. The total visits were **42,756** and there were **94,087** pageviews.

OUTREACH

The Ombudsman was invited to speak at several events in 2013-2014, including at the 11th International Baku Conference of Ombudsmen in Azerbaijan, and the Financial Management Institute's Public Sector Management Workshop in Toronto, both in June 2013, and Carleton University Alumni Association's Ottawa Leadership Luncheon in November 2013.

Our Office was also represented at various outreach and community events involving, among others, the Ontario Bar Association and the law faculties of the University of Ottawa, University of Toronto and York University.

As well, the Ombudsman and staff participated in several charitable events, including the Pride and Remembrance Run in July 2013 and the Run for the Cure in October 2013.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Ombudsman


RUN

Case Summaries

MINISTRY OF THE ATTORNEY GENERAL

Legal Aid Ontario

Forgiven and Forgotten

A woman complained to the Ombudsman that a collection agency was asking her to repay an unpaid debt of $5,900 to Legal Aid Ontario. She had used the services of a Legal Aid lawyer in 2004 in custody proceedings involving her grandchildren, but said she was never told she would have to pay. She tried calling Legal Aid for clarification of the decade-old debt, but got no response.

Ombudsman staff asked Legal Aid to review the woman's file. It revealed that she had signed an agreement in 2004 to reimburse the agency, but the debt was forgiven in 2007 because her financial situation changed and she was no longer required to pay. This change was never passed on to Legal Aid's client account services department and wasn't reflected on her account. When they discovered this, Legal Aid staff immediately let the woman know she did not owe anything, and the collection efforts ceased.

MINISTRY OF COMMUNITY AND SOCIAL SERVICES

Developmental Services

In Case of Emergency

The mother of a 21-year-old man with autism who cannot communicate verbally and requires assistance with everyday tasks was worried about how he would be cared for if she underwent cancer surgery. She had already had a mastectomy and was facing further treatment and possible hospitalization. Her son lived with her and was on a long waiting list for placement in a group home.

When Ombudsman staff brought the case to the attention of the Community Program Manager at the Ministry of Community and Social Services, the manager worked with the local service co-ordination agency to prepare an emergency plan that would pay for temporary placement of the man if his mother required further treatment. The mother was relieved know her son would be cared for if an emergency arose.

Case Summaries

Preventing Future Tragedies

The parents of a 28-year-old man with autism who drowned in the bathtub of his group home asked the Ombudsman for help in obtaining information about their son's death. Sixteen months after the tragedy, they were still waiting for someone to explain exactly what had happened. They also wanted to make sure that other people living in group homes were protected from the same fate.

Ombudsman staff asked the Office of the Chief Coroner and the Ministry of Community and Social Services what steps had been taken in the wake of the man's death. They learned that because a coroner's investigation had deemed it an accident and a police investigation found no criminal wrongdoing, the Ministry had taken no action to prevent similar incidents.

The Regional Supervising Coroner met with the couple to answer their questions, and they raised concerns that the group home had repeatedly left their son in the bathtub unsupervised for hours at a time. As a result, the Regional Supervising Coroner issued a recommendation to both the Ministry of Community and Social Services and the Ministry of Children and Youth Services to prevent similar deaths.

The recommendation asks both ministries to inform care providers of the increased risk of drowning for people with autism spectrum disorder. It also asks the ministries to require that group homes develop protocols to prevent accidental drowning, including supervised bathing sessions or shower-only facilities. Our Office will monitor the ministries' response to the recommendation.

Family Responsibility Office

Pay it Forward

A man complained to the Ombudsman after the Family Responsibility Office (FRO) required him to pay **$720** to cover two child support payments from 2008 and 2009. He had been paying child support through deductions from his paycheque for seven years without incident, but in 2011, when his wife obtained an increase in child support, the FRO reviewed his file and determined the two payments were missing. He had proof of the paycheque deductions, but the FRO insisted he pay again.

After Ombudsman staff intervened, the FRO provided the man's employer with bank records showing that it never received the two payments in question. The employer agreed to send the money to the FRO, which, in turn, reimbursed the man the full $720.

Case Summaries

Lost in America

A mother of three complained to the Ombudsman that her children's father – who moved to the U.S. in 2005 – had not made regular child support payments since 2006. The father owed $1,600 when he first moved away, but was still making the occasional voluntary payment. When he stopped in 2006, the FRO failed to register the case with a U.S. enforcement agency for more than two years. By the time the woman came to the Ombudsman in 2012, the father owed **$24,000** in support.

The FRO eventually registered the case with a U.S. enforcement agency, but the family was required to undergo DNA testing before the agency could collect the support payments. The FRO failed to inform the mother of the DNA testing requirement, and it would not provide the U.S. agency with her contact information.

After the mother complained to the Ombudsman, the FRO acknowledged the problems in the case and contacted the U.S. agency. The DNA tests were done in Ontario and two months later, the mother began receiving monthly support payments.

Ask and You Shall Receive

The mother of a 15-year-old boy with developmental disabilities complained to the Ombudsman that the FRO would not release more than $14,000 in child support payments it had collected from the boy's father since 2010.

The woman had obtained an order for child support in another country. She had since moved to Ontario and the boy's father moved to the U.S. His payments were to be held in a bank account until the FRO registered the child support order with an Ontario court.

When Ombudsman staff contacted FRO officials, they initially said they were waiting for information from the jurisdiction where the father now lived. However, our review found there was no evidence that the FRO had asked for the information. After our intervention, FRO staff obtained the documents they needed, the support order was registered in Ontario in April 2013, and the FRO gave the mother a cheque for **$14,281.71**.

Case Summaries

ONTARIO DISABILITY SUPPORT PROGRAM

Cheques and Balances

A woman receiving social assistance through the Ontario Disability Support Program (ODSP) who was also entitled to spousal support payments from her ex-husband through the Family Responsibility Office (FRO) complained to the Ombudsman that she had not received any spousal support in several months. Normally in such cases, under arrangements known as "assignments," the FRO sends the support payments to the ODSP, which keeps some of the funds as reimbursement.

The woman complained that although the FRO confirmed it had collected payments from her former spouse, her ODSP worker told her that the FRO had not sent them. When Ombudsman staff contacted the ODSP worker, she acknowledged that she had not checked her computer to verify whether any funds had been sent by the FRO. An Ombudsman investigator raised the matter with the Ministry, which contacted the worker's manager to resolve the situation.

The woman then received a cheque for **$2,026**, for the months of support payments that she had been entitled to receive.

A Real Lift

The father of a 24-year-old man who has cerebral palsy and uses a wheelchair complained to the Ombudsman after the ODSP refused him financial assistance to cover the repair and maintenance costs of an elevator and outdoor mechanical porch lift – nearly $4,500 in all.

ODSP officials told him this was because the Community Start-Up and Maintenance Benefit, which once helped pay for this, was discontinued in January 2013. They suggested he seek funding from charities and support groups, but none were able to help him, including the Ontario March of Dimes and the Ontario Federation for Cerebral Palsy.

Ombudsman staff reviewed an ODSP funding directive for "mobility devices, batteries and repairs" with the ODSP regional manager. ODSP staff initially said the directive applied to personal lifting devices, not elevators and porch lifts, but the manager reviewed the family's case and agreed that it could also apply to their request.

Given that the family was unable to get financial help from any other agency, the ODSP provided them with **$1,686.53**, which they had paid out of pocket, and their private insurance covered the rest.

Case Summaries

MINISTRY OF COMMUNITY SAFETY AND CORRECTIONAL SERVICES

Caught on Video

In January 2013, an inmate at the Ottawa-Carleton Detention Centre slipped and fell on a wet floor in an area where staff had neglected to put up a "wet floor" warning sign. The fall was the beginning of a painful ordeal that he asked the Ombudsman to investigate once he was out of jail and no longer feared reprisal.

The fall broke the man's femur bone. Despite his protests that he was in pain and could not walk, correctional staff lifted him up and walked him back to his cell. A nurse checked his leg and told him he only needed an ice pack. In a scene that was captured on the institution's internal video cameras, more staff then carried him down a flight of stairs in a wheelchair, allowing it to bump hard against each stair. Correctional officers repeatedly told him to "shut up" when he complained about the pain.

Ninety minutes after the fall, another nurse called an ambulance. He required surgery for the broken leg and spent three weeks in hospital.

Ombudsman staff brought the complaint to the facility's deputy superintendent, who reviewed the video evidence and launched a full internal investigation, which found several faults in the way correctional staff responded to the incident. The inmate should not have been moved from where he fell, he should have been assessed immediately by health care staff and transported by paramedics to hospital, and several policies and rules with regard to first aid and report writing were not followed.

The internal investigation recommended that the correctional officers involved attend first aid training and that disciplinary action be taken. All recommendations from the investigation were accepted. At the Ombudsman's suggestion, the deputy superintendent also sent the man a letter of apology and informed him of the outcome of the internal investigation.

The man expressed his profound thanks to Ombudsman staff for drawing attention to the incident to ensure other inmates would not endure the same experience.

Care and Custody

The sister of a young woman who died from stomach cancer not long after being released from jail complained to the Ombudsman that her sister had not received proper medical care behind bars. Health care staff at the institution repeatedly sent her to the local hospital, but each time, the hospital assessed her and returned her to jail, where staff did their best to care for her, despite her serious condition.

Ombudsman staff brought the case to the Ministry of Community Safety and Correctional Services' corporate health care manager, who arranged for the health care manager of the jail to meet with the woman's family. As well, Ombudsman staff contacted the Chief Coroner, who assigned the local coroner to conduct an investigation.

The local coroner made a number of recommendations, including that both the hospital and jail ensure relevant medical information accompanies inmates who are transferred to hospital, and that health care professionals at both facilities communicate more clearly and frequently.

After the investigation, the Regional Supervising Coroner met with the family to discuss the recommendations. Both the jail and hospital accepted his recommendations and implemented a new policy to improve inmate treatment.

Case Summaries

Basin Blues

An inmate complained to the Ombudsman after he was held in segregation for two weeks in a cell with a broken sink and no clean running water. He had been using the toilet to wash his hands and his only drinking water came from a jug outside his cell that correctional staff did not change or fill regularly.

Ombudsman staff raised the issue with the facility's superintendent, who confirmed the sink was not working. The superintendent promptly decommissioned the cell and assured Ombudsman staff that it would not be used until the sink was fixed.

Not What the Doctor Ordered

After spending five days in jail before being released on bail, a woman complained to the Ombudsman that she was refused her prescribed medication at the detention centre. The woman had been taking the drug for pain relief for several years, and her doctor told the jail's doctor it was required. Without it, she experienced severe withdrawal, including prolonged vomiting, diarrhea, chills, sweats, dizziness and pain.

Ombudsman staff raised the issue with the Ministry of Community Safety and Correctional Services' corporate health care manager, who reviewed the woman's medical file and met with the facility's health care staff to determine what had happened. The manager identified several areas where Ministry policy was not followed and where the detention centre's health care could be improved and created a "what not to do" training presentation for jails across the province, based on the case. The centre also sent the woman a letter of apology.

Case Summaries

MINISTRY OF ENERGY

Hydro One

Going Through Withdrawal

Two weeks before Christmas, a woman was distressed to learn that Hydro One had taken **$8,390** from her bank account. She had authorized automatic payments to the utility through her account, but was astonished by the unexpectedly large bill. When she called Hydro One to ask why the amount was so high, its customer service staff told her it was a "catch-up" bill to make up for 22 months of estimated billings that it determined were too low.

Ombudsman staff raised the woman's case with Hydro One officials, who acknowledged that, in fact, they had failed to obtain a meter reading during the 22 months. They agreed to repay the woman the entire amount.

Case Summaries

Shut Out

An elderly couple living on disability pensions complained to the Ombudsman about the ordeal they went through in trying to pay their Hydro One bills. When no bills arrived between July and September 2013, they called Hydro One to find out what they owed. They were told they were not sent a bill because Hydro One's records showed their home had been repossessed. Not only that, Hydro One would not discuss details with them because its records showed they were no longer the property owners. They described one customer service manager's attitude as: "This is what happens when your house gets repossessed."

The customers did their own research and determined that Hydro One was confusing their property with another home – with the same street address but in a different city. Ombudsman staff persuaded Hydro One to speak with the couple and acknowledged the error by crediting part of their bill.

Powerful Shock

A man who rebuilt his family cottage into his retirement dream house received no bills from Hydro One for 31 months – then was stunned to receive a bill for **$12,115.72**.

Ombudsman staff looked into the issue and determined that annual meter readings should have been done on the property, which was classified as seasonal, but none had been done for 2012 or 2013. Hydro One could not provide reasons why the readings were not done and no bills were sent to the man until 2014.

Hydro One acknowledged the error and credited **$3,500** to the man's account. He was also told he could apply to have his home reclassified from seasonal to residential, which would result in a reduced hydro rate and more frequent billings based on actual power usage.

Case Summaries

Serious Disconnect

Although she had received no bills from Hydro One for nine months, the owner of a rental property continued to make payments on what she estimated to be her tenants' power usage. Despite this, Hydro One officials showed up at the property four times, claiming the account was in arrears and threatening to disconnect the electricity.

The woman complained to the Ombudsman that she spent several hours on the phone with Hydro One each time, and was repeatedly assured that the problem was on their end and would be fixed.

Ombudsman staff determined that when Hydro One switched to its new billing system in May 2013, a mistake was made on the account for the rental property, deeming it vacant. Since the tenants continued to use electricity, Hydro One's computers automatically generated disconnection orders. Had the tenants not been home each time Hydro One employees visited, their electricity would have been cut off.

As for the payments the property owner made, Hydro One had wrongly directed them to her residential account. She was given a service credit of $370.88 and an additional goodwill credit of $231.21, for a total of $602.09 to be applied against the $1,993.68 arrears that had accumulated on her rental property, and she began receiving monthly bills.

Return to Sender

After Hydro One launched its new billing system in spring 2013, a Canada Post manager in a small community noticed that its bills no longer included rural mailbox site and compartment, and therefore could not be delivered to customers. As the number of undeliverable bills mounted, the manager tried several times to bring the problem to Hydro One's attention, without success.

After the manager complained to our Office, Ombudsman staff raised the complaint with Hydro One's director of customer service, who arranged to have Canada Post return the undeliverable bills so Hydro One could readdress them and contact the customers.

Case Summaries

MINISTRY OF GOVERNMENT SERVICES

ServiceOntario

As Canadian as Health Care

After moving from Quebec to Ontario in October 2011, a man tried several times to obtain an Ontario Health Insurance Plan (OHIP) card at a ServiceOntario office. Each time, he was told that his birth certificate showed he wasn't a Canadian citizen and that he would have to apply as an immigrant – despite having lived in Quebec most of his life.

In fact, the man's birth certificate was issued by the Department of National Defence, and showed he was born in 1963 in Germany, where his parents were serving in the Canadian military and stationed at a Canadian Armed Forces base. He also had a letter proving that he and his parents were Canadian citizens. However, before he was able to obtain an OHIP card, he experienced several catastrophic health problems that put him in hospital for almost three months. He had hospital bills for more than $100,000, and was worried about how he would pay them.

Once Ombudsman staff brought the man's dilemma to Ministry of Health and Long-Term Care officials, they reviewed the file and confirmed the man was eligible for OHIP coverage dating back to January 2012. They also sent him a letter, assuring him that any money he paid for services during that time that should have been covered by OHIP would be reimbursed.

Beginner's Bad Luck

A young driver who was caught speeding received a letter from the Ministry of Transportation requiring him to surrender his G1 (beginner level) licence for 30 days and pay a fee to have it reinstated. He visited a ServiceOntario office where an employee processed his payment, then returned the licence to him with a sticker on it that said the licence was only good for identification purposes.

When he returned after 30 days to have his licence reinstated, he learned that the suspension had not taken effect because the licence should have been taken away from him. As a result, he would have to surrender it and wait another 30 days to have it reinstated.

After the Ombudsman raised the driver's complaint with ServiceOntario, it sent a written apology to the young driver for its employee's mistake and sent a notice to all staff, reminding them of the proper procedure to follow in such cases.

Case Summaries

MINISTRY OF HEALTH AND LONG-TERM CARE

The Right Prescription

A mother contacted the Ombudsman on behalf of her 14-year-old son, who suffers from sytemic-onset juvenile idiopathic arthritis, complicated with macrophage activation syndrome. Her son couldn't take the drug normally funded and approved for the treatment of the first condition, Tocilizumab, because it can be dangerous to people with the second condition. Because of this, his physician had prescribed another drug, Anakinra.

The boy did well on this drug for seven months, thanks to funding from the SickKids Foundation and a limited supply provided by the drug manufacturer. The mother feared that when the supply ran out, the family could not afford the drug, which would cost them up to $20,000 per year. But the Ministry's Exceptional Access Program denied their physician's application to have it funded because it was not on its list of approved drugs for children, and an alternative (Tocilizumab), was available.

After Ombudsman staff raised the case with the director of the Ministry's Drug Programs Branch and explained that the alternative drug was not an option for the boy, its expert advisory board recommended that the criteria for funding Anakinra be changed and posted online. The Ministry also approved funding for the boy's medication under the new formula.

In the Neighbourhood

A man complained to the Ombudsman on behalf of his father, who was unable to receive rehabilitation services more than eight months after having a stroke in November 2012. Although the father's doctor, cardiologist, and physiotherapist supported his application for rehabilitation therapy, he was turned away at three different hospitals because he did not live within their geographical catchment area.

When the man contacted the Ombudsman, his father was receiving only 30 minutes of physiotherapy a week, and family members had resorted to researching physiotherapy online so they could assist him with exercises themselves. Ombudsman staff pointed out to Ministry officials that provincial legislation prohibits hospitals from denying patients service based on where they live.

The Ministry escalated the matter to all the chief executive officers of the hospitals in the Local Health Integration Network, to make sure they all understood the legislation. As a result, the man was accepted into a rehabilitation program near his home.

Case Summaries

Too Close for Comfort

In early 2012, the Ombudsman was contacted by Nickel Belt MPP France Gélinas on behalf of a constituent in Westree who complained that the Northern Health Travel Grant would not cover the costs of her accommodation in Sudbury, where she had a medical appointment, because she lived too close to qualify. The grant covers accommodation for northern Ontario residents who have to travel 200 kilometres or more for treatment; Westree is 193 kilometres from Sudbury.

Ombudsman staff raised concerns with the Ministry about the need for greater flexibility in the program in cases like the woman's – who was required to stay overnight in Sudbury so she could take preparatory treatment for a colonoscopy the next day. For two years, Ministry staff assured our Office that they would review the program guidelines and create an internal appeal process, but progress was slow.

In April 2014, senior Ministry officials confirmed that the woman's November 2011 application was being reassessed and an appeal process was being developed. Ombudsman staff will continue to monitor the Ministry's review of the case and its progress on setting up an appeal process.

Case Summaries

MINISTRY OF TRAINING, COLLEGES AND UNIVERSITIES

Have Business, Will Travel

An electrical contractor complained to the Ombudsman after the Ministry of Training, Colleges and Universities asked him to repay the **$1,269** he received from the Ontario Self-Employment Benefit program. The program provides unemployed people with financial support while they develop and start new businesses.

During the man's participation in the program, he was paid $423 per week while he set up a new contracting service, providing technical services and energy analysis to various industries. Although his new business was based in Ontario, some work required him to travel out of the country on short notice. The Ministry approved two such travel requests, but denied a third because the man had travelled outside Canada without prior approval. It ended his participation in the program when he refused to repay the funds he received during that time.

The man explained to the Ombudsman that he had responded to a client's urgent needs and would have lost a valuable contract if he had waited three weeks for the Ministry's approval. In addition, the job was more complex than anticipated and he was out of the country longer than expected.

Ombudsman staff explained the man's circumstances to Ministry officials, and asked if there was any flexibility given the nature of the man's work and the fact he had established a sustainable business, which is the objective of the program. In response, the Ministry agreed that the man didn't have to repay the money he received while he was outside of Canada.

How Do You Spell Relief?

A student complained to the Ombudsman after the Ontario Student Assistance Program (OSAP) denied his application for a provincial grant that would give him 30% off tuition for the 2012-2013 academic year.

The discount was available as a provincial grant for eligible full-time students attending a public college, university or OSAP-approved private post-secondary school, and any student applying for OSAP funding is automatically considered for the rebate.

OSAP officials told Ombudsman staff the student had been assessed as eligible for the grant, but it could not be approved because they were unable to verify the income of his mother, with whom he lived. It turned out that the student had misspelled his mother's name on the application, meaning OSAP could not obtain the information it needed. However, the student was never told of the mistake; when he checked his application status online, he was only told it was "to be determined."

Once the problem was explained, the student immediately provided the correct spelling and information. OSAP agreed to reassess his application and approved him for the 30% tuition grant and a loan, for a total of **$1,960** in assistance.

MINISTRY OF TRANSPORTATION

Deadline Driven

A driver who suffered what he believed to be a seizure in April 2013 was diagnosed by a neurologist and, as required by the Ministry of Transportation, had his licence suspended pending a medical review. On October 28, 2013, his doctor faxed documentation to the Ministry to prove that he had been seizure-free for six months, and thus eligible to have his licence reinstated.

However, the Ministry never received the fax. When the doctor learned this and sent it again a month later, the Ministry told the man it would take another 30 business days to process. The man contacted the Ombudsman for help, saying he would lose his job if he did not have his driver's licence reinstated by mid-December.

Ombudsman staff explained the situation to the Ministry, and the next day, its Driver Licensing Medical Review Section confirmed it had received the medical information and reinstated the man's licence. The man was delighted, telling Ombudsman staff: "You've made my Christmas and you've made my job!"

Case Summaries

Mail Mix-up

A paramedic complained to the Ombudsman after his employer told him his driver's licence had been suddenly downgraded from a Class F to a Class G. Because he required a Class F licence for his job, he was unable to work for nearly three weeks.

The Ministry of Transportation's Driver Licensing Medical Review Section told him his licence was downgraded because he did not respond in time to a letter it sent. The letter was a follow-up to treatment he had received for deep vein thrombosis; drivers with this condition must submit a physician's verification that they are fit to drive. The letter warned that without this information, his licence would be automatically downgraded by a certain date. However, he never received the letter.

Although the Ministry agreed to reinstate the paramedic's Class F licence, he was concerned that the record of the temporary downgrade could affect his future employment.

The Ombudsman's inquiries revealed that hundreds of other drivers had had similar experiences. In fact, due to a computer glitch, letters addressed to **1,399** drivers over a three-day period in May and June 2013 were never sent. Once this mix-up was uncovered, the Ministry contacted each driver and cleared the record of any whose licences had been unfairly downgraded or suspended.

Your Feedback

"I want you to know that my colleagues and I greatly value your efforts, and those of your staff, to foster greater openness and transparency. Know that we are committed to continuing to work with you to meet the priorities of the people of Ontario – and deliver the results they deserve."

Letter from Premier Kathleen Wynne, July 23, 2013

"I recently called with an urgent matter... After I called your office, I received a call from FRO about the good news ... I do not know what (your staff member) said to them, however, I want to thank her."

Complainant

"Thank you to André Marin and his co-workers for the excellent job they have been doing for the past few years. In an age where it's difficult to find people who back up their convictions with actions, your office is a bright light – at the end of some very long, dark tunnels. You have made an immeasurable difference in so many people's lives. Everyone I talk to about your office is glad you're fighting for us. Thanks for taking the difficult path, to make things better."

Robert Jackson
Ottawa

"If our Canadian government had more people like you, our country would rank first in the world. There must be a lineup to join members of your team. Who would not want to work with someone with your ethics and business sense? I still can't believe there is a government department that actually follows up to see if the ministers did what they promised. You are a breakthrough in government operations. Congratulations.....and kudos for your team members as well."

Peggy Andrews
Welland, Ontario

"I ... simply wanted to write and say how fortunate Ontarians (and all Canadians) are in having you as their Ombudsman. ... It is clear that you are passionate about your work and are hugely committed to doing the right thing and also to tackle head-on the most difficult and complex of cases that come to your attention. I admire your courage and integrity... how fortunate for the disenfranchised that you are there to represent them. Bravo to you and your dedicated staff."

Richard Gray
Summerland, B.C.

"Your report [*The Code*] demonstrates that there is clearly a need for ongoing and independent oversight of provincial corrections, and we laud your organization's efforts to date to bring these issues to the forefront."

Paula Ossok, Executive Director, John Howard Society of Ontario

"I would like to convey my gratitude for your staff's guidance in helping us to improve our complaints handling process. Your staff graciously provided opportunities for the DIOC Secretariat to observe the work of Early Resolution Officers and to participate in training workshops hosted by your office. Your staff also offered sound advice on how we can better meet public expectations and communicate with those seeking assistance from our Council. The advice and lessons learned from these opportunities were incorporated and helped to enhance our complaints process."

Hon. Joseph C.M. James, Chair, Death Investigation Oversight Council

"This high-quality report [*The Code*] demonstrates what an important role you play in matters of justice and equality. I hope it will have a permanent preventive effect and ensure more rigorous scrutiny of correctional facilities, so that they meet their obligation to treat all prisoners with respect."

Raymonde Saint-Germain
Quebec Ombudsman

Your Feedback

Your Feedback

"Thank you for your work on advocating for people with developmental disabilities and [Autism Spectrum Disorder] and for taking the time to join us on ASD Awareness Day."

Marg Spoelstra, Executive Director, Autism Ontario

"I wanted to take this opportunity to express my gratitude to you for all the work you have done with us. I have very much valued the work you do on behalf of patients and the effort you have put in to understanding our program and the difficult decisions we have to make in a way that is responsible and fair to all Ontarians. As a result of your efforts with patients, I believe they understand our approach much better and we have been able to improve and sensitize our decision-making. This is an iterative process and we are much better off as a result of the relationship that has developed with you."

Email from former senior Health ministry manager

"To my surprise, I received a call in early October that [our son] had been accepted [into a residential program for adults with developmental disabilities]. Things are working out; it was an adjustment at first, but he seems to be settling well with the workers and the new environment. May I take this opportunity to thank you for all your help on his file. We truly appreciate all your efforts. I have no idea what transpired, but am so very grateful that things worked out for our family."

Complainant

"Thank you for your professionalism and dedication. Thanks for caring about issues that are important to Ontarians and representing people's rights. We really appreciate you. You do everything with professional excellence and you choose to help people. That means a lot to people."

Complainant

"I feel that your office is the only provincial body who really cares and wants to help make a difference."

Camille Parent

"Thank you for your assistance in resolving the payment issue... I don't know how we would have managed without your help. Good job!"

Complainant

"I just wanted to thank you for your continued support. You are the first person I have dealt with in all these years that actually keeps their word and makes things happen with regards to the FRO. Thank you for being a voice for my children. We do appreciate it very much."

Complainant

"Thank you for all your help and patience. A kind person like you makes this world a better place."

Complainant

"Thank you so much for your help ... I am very pleased that you were able to convince FRO that they need to collect the arrears [from my ex-husband]; now some $241,500. Thank you for your determination in pursuing FRO and helping them understand the situation."

Complainant

Your Feedback

Comments from Twitter

> Thanks for what you do. Keep being the real eyes and ears of our province.
>
> @[illegible]

> You are the last hope for many. The very last hope. Our liberty depends upon accountable government.
>
> @[illegible]

> Great job in 2013! You have been busy. You have been relevant. You have brought transparency and accountability.
>
> @CrudeLaw

> Ontario Ombudsman Andre Marin has earned our respect for his contribution to the public sector.
>
> @[illegible]

> We admire your dedication and passion to stand up for the vulnerable, and advocate for what's right.
>
> @Lisa[illegible] Smith

> Keep working for the needed changes, one voice for the thousands that feel they have no voice.
>
> @Mary_OGrady

> If you're from Ontario or from anywhere in Canada for that matter, you need to Follow @Ont_Ombudsman! Keeping Ontario Government accountable.
>
> @KNoWITALL

Your Feedback

In the Media

"The Ontario ombudsman's investigation into police de-escalation techniques across the province needs to be done."

Lee Prokanka, Hamilton Spectator, August 24, 2013

"I'm glad to see [the Ombudsman] provide more oversight of a government-owned utility's billing practices, which have created financial hardship for many customers."

Ellen Roseman, Toronto Star, February 8, 2014

"An ombudsman shines light on the inner workings of public institutions to uncover hidden misdeeds, and by so doing, bring about positive change. An effective ombudsman has to be fearless and not afraid to call things as he sees them, and since he took up the job, Marin has done admirable work. He doesn't stand on ceremony, and is not afraid to step on toes, going where the facts lead him."

Editorial, Ottawa Citizen, September 18, 2013

"[Ombudsman André] Marin is effective at his job. His investigation into insider lottery winners at the provincial lottery corporation was devastating and forced the government to address an open sore it clearly wanted to ignore.... he follows the facts where they take him and is unafraid of upsetting his political masters.... He turned the sleepy ombudsman's office into a regular headline-grabber by launching an outpouring of investigations and ensuring the media knew of his findings. That's not a bad thing. If exposing government activities to daylight upsets insiders, the cure is to clean up their act."

Kelly McParland, National Post, March 7, 2014

"Canadians and Ontarians don't have to look far to see the effectiveness of independent oversight. The work of Sheila Fraser and Kevin Page in Ottawa, and of André Marin in Ontario has had tremendous public benefit in holding our elected officials accountable. They will never fully stop corruption, but they will publicly expose it. Through the years, I have no doubt that these watchdogs have saved citizens billions of dollars. They have done this on our behalf because they were the public's eyes on government's spending."

Larry McKenzie, letter to London Community News, June 30, 2013

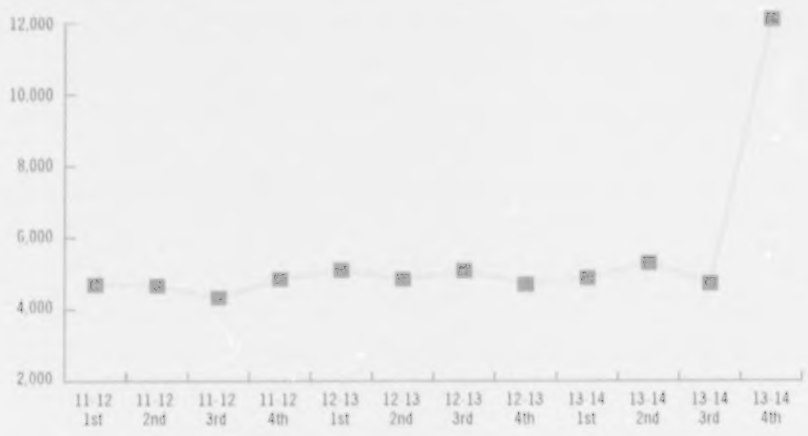
"Ontario Ombudsman André Marin has gained a reputation for fighting for the little guy who's stuck in provincial bureaucratic hell."

David Reevely, Ottawa Citizen, March 27, 2014

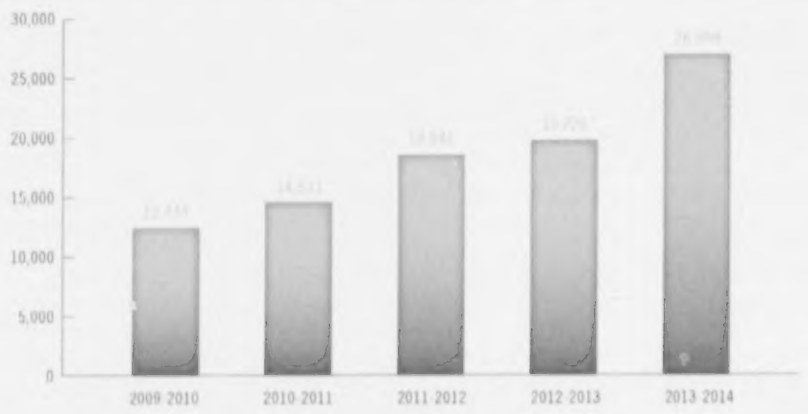
Appendix 1

COMPLAINT STATISTICS

CASES RECEIVED BY QUARTER
2011-2012 TO 2013-2014



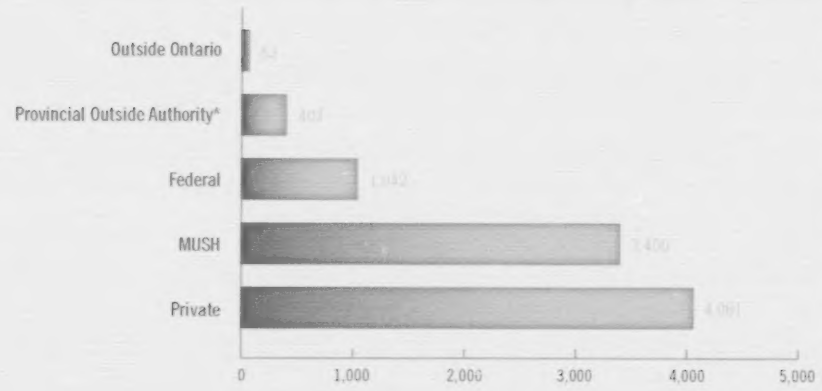
TOTAL CASES RECEIVED
FISCAL YEARS 2009-2010 TO 2013-2014



Appendix 1

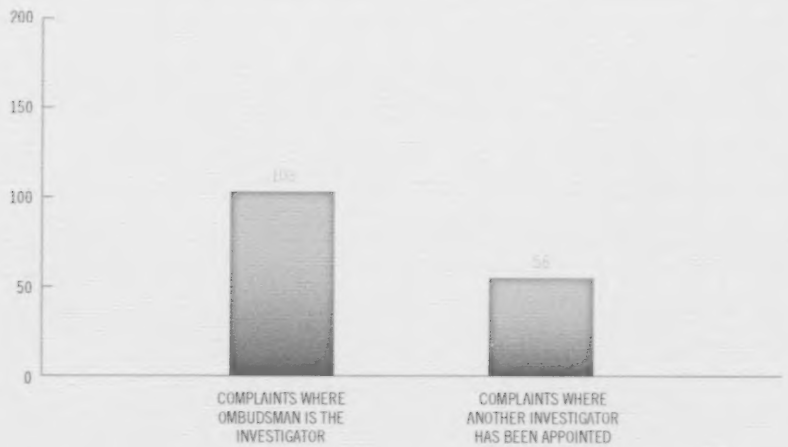
COMPLAINT STATISTICS

CASES OUTSIDE THE OMBUDSMAN'S AUTHORITY
RECEIVED 2013-2014 TOTAL: 8,969



*For examples, cases received about courts, Stewardship Ontario and Tarion.

CASES RECEIVED ABOUT CLOSED MUNICIPAL MEETINGS
2013-2014*



*Note: Details of these cases will be released in a separate Annual Report later this year.

Appendix 1

COMPLAINT STATISTICS

TOP 15 PROVINCIAL GOVERNMENT ORGANIZATIONS AND PROGRAMS COMPLAINED ABOUT IN 2013-2014*

		NUMBER OF CASES	PERCENTAGE OF ALL CASES WITHIN AUTHORITY
1	HYDRO ONE	6,961	38.60%
2	FAMILY RESPONSIBILITY OFFICE	1,157	6.42%
3	ONTARIO DISABILITY SUPPORT PROGRAM	621	3.44%
4	WORKPLACE SAFETY AND INSURANCE BOARD	552	3.06%
5	DEVELOPMENTAL SERVICES PROGRAMS	501	2.78%
6	DRIVER LICENSING	244	1.35%
7	PUBLIC GUARDIAN AND TRUSTEE	180	1.00%
8	LEGAL AID ONTARIO	150	0.83%
9	ONTARIO HEALTH INSURANCE PLAN	149	0.83%
10	DRIVER LICENSING – MEDICAL REVIEW SECTION	141	0.78%
11	LANDLORD AND TENANT BOARD	138	0.77%
12	ONTARIO STUDENT ASSISTANCE PROGRAM	134	0.74%
13	SERVICEONTARIO	124	0.69%
14	COMMUNITY CARE ACCESS CENTRE	122	0.68%
15	MUNICIPAL PROPERTY ASSESSMENT CORPORATION	116	0.64%

TOP 10 CORRECTIONAL FACILITIES COMPLAINED ABOUT IN 2013-2014

		NUMBER OF CASES	PERCENTAGE OF ALL CASES WITHIN AUTHORITY
1	CENTRAL EAST CORRECTIONAL CENTRE	532	2.95%
2	CENTRAL NORTH CORRECTIONAL CENTRE	430	2.38%
3	OTTAWA-CARLETON DETENTION CENTRE	416	2.30%
4	TORONTO WEST DETENTION CENTRE	289	1.60%
5	MAPLEHURST CORRECTIONAL COMPLEX	254	1.41%
6	VANIER CENTRE FOR WOMEN	219	1.21%
7	HAMILTON-WENTWORTH DETENTION CENTRE	214	1.19%
8	ELGIN-MIDDLESEX DETENTION CENTRE	186	1.03%
9	NIAGARA DETENTION CENTRE	142	0.79%
10	TORONTO EAST DETENTION CENTRE	116	0.64%

Appendix 1

COMPLAINT STATISTICS

CASES EXCLUDING CORRECTIONAL FACILITIES RECEIVED 2013-2014 BY PROVINCIAL RIDING*

Ajax-Pickering	109	Niagara West-Glanbrook	115
Algoma Manitoulin	328	Nickel Belt	216
Ancaster-Dundas-Flamborough-Westdale	121	Nipissing	276
Barrie	161	Northumberland Quinte West	223
Beaches-East York	108	Oak Ridges-Markham	125
Bramalea Gore Malton	119	Oakville	80
Brampton-Springdale	85	Oshawa	166
Brampton West	124	Ottawa Centre	89
Brant	111	Ottawa-Orleans	142
Bruce Grey Owen Sound	312	Ottawa South	86
Burlington	117	Ottawa-Vanier	108
Cambridge	107	Ottawa West Nepean	86
Carleton-Mississippi Mills	195	Oxford	119
Chatham Kent Essex	125	Parkdale High Park	118
Davenport	87	Parry Sound-Muskoka	440
Don Valley East	87	Perth Wellington	147
Don Valley West	80	Peterborough	187
Dufferin-Caledon	201	Pickering-Scarborough East	86
Durham	181	Prince Edward-Hastings	333
Eglinton-Lawrence	99	Renfrew-Nipissing-Pembroke	352
Elgin-Middlesex-London	185	Richmond Hill	55
Essex	168	Sarnia-Lambton	167
Etobicoke Centre	80	Sault Ste. Marie	182
Etobicoke-Lakeshore	132	Scarborough-Agincourt	67
Etobicoke North	93	Scarborough Centre	80
Glengarry-Prescott-Russell	256	Scarborough-Guildwood	119
Guelph	97	Scarborough-Rouge River	37
Haldimand-Norfolk	142	Scarborough Southwest	105
Haliburton-Kawartha Lakes-Brock	374	Simcoe-Grey	198
Halton	103	Simcoe North	236
Hamilton Centre	181	St. Catharines	133
Hamilton East-Stoney Creek	124	St. Paul's	115
Hamilton Mountain	143	Stormont-Dundas-South Glengarry	250
Huron-Bruce	249	Sudbury	147
Kenora-Rainy River	151	Thornhill	80
Kingston and the Islands	162	Thunder Bay-Atikokan	124
Kitchener Centre	93	Thunder Bay-Superior North	153
Kitchener-Conestoga	83	Timiskaming-Cochrane	309
Kitchener-Waterloo	73	Timmins-James Bay	160
Lambton-Kent-Middlesex	212	Toronto Centre	195
Lanark-Frontenac-Lennox And Addington	423	Toronto-Danforth	106
Leeds-Grenville	359	Trinity-Spadina	168
London-Fanshawe	129	Vaughan	87
London North Centre	138	Welland	146
London West	157	Wellington-Halton Hills	137
Markham-Unionville	54	Whitby-Oshawa	122
Mississauga-Brampton South	72	Willowdale	77
Mississauga East-Cooksville	68	Windsor-Tecumseh	119
Mississauga Erindale	96	Windsor West	144
Mississauga South	77	York Centre	107
Mississauga Streetsville	74	York Simcoe	205
Nepean-Carleton	147	York South-Weston	88
Newmarket Aurora	99	York West	80
Niagara Falls	150		

*Where a valid postal code is available.

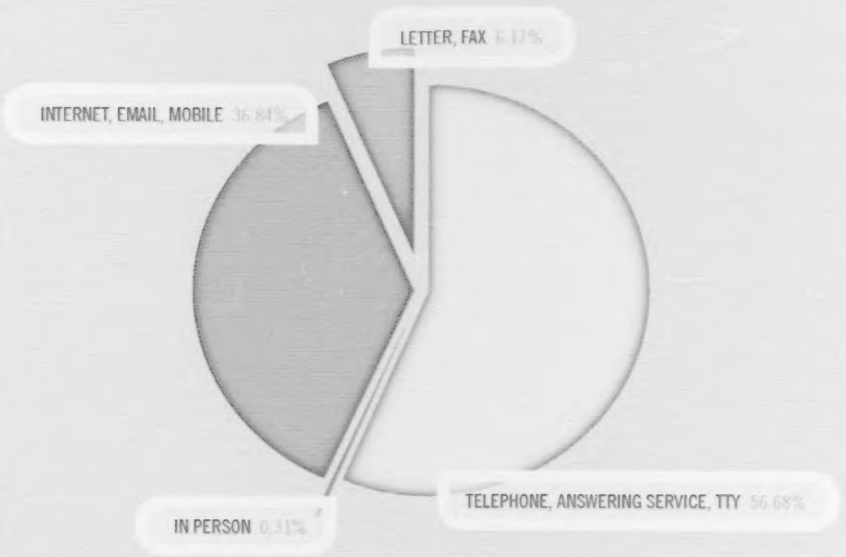
Appendix 1

COMPLAINT STATISTICS

MOST COMMON TYPES OF CASES RECEIVED DURING 2013-2014

1	DECISION WRONG, UNREASONABLE OR UNFAIR
2	ACCESS TO, OR DENIAL OF SERVICES; INADEQUATE OR POOR SERVICE
3	COMMUNICATION INADEQUATE, IMPROPER OR NO COMMUNICATION
4	FAILURE TO ADHERE TO POLICIES, PROCEDURES OR GUIDELINES; UNFAIR POLICY/PROCEDURE
5	DELAY
6	ENFORCEMENT UNFAIR OR FAILURE TO ENFORCE
7	LEGISLATION AND/OR REGULATIONS
8	GOVERNMENT FUNDING ISSUE
9	BROADER PUBLIC POLICY ISSUE
10	INTERNAL COMPLAINTS PROCESS; LACK OF A PROCESS, UNFAIR HANDLING OF COMPLAINT

HOW CASES WERE RECEIVED 2013-2014



Appendix 1

COMPLAINT STATISTICS

DISPOSITION OF CASES
2013-2014

Appendix 1

COMPLAINT STATISTICS

TOTAL CASES RECEIVED 2013-2014
FOR PROVINCIAL GOVERNMENT MINISTRIES AND SELECTED PROGRAMS*

MINISTRY OF AGRICULTURE AND FOOD		15
MINISTRY OF THE ATTORNEY GENERAL		889
ALCOHOL AND GAMING COMMISSION OF ONTARIO	12	
ASSESSMENT REVIEW BOARD	21	
CHILDREN'S LAWYER	40	
CRIMINAL INJURIES COMPENSATION BOARD	29	
HUMAN RIGHTS LEGAL SUPPORT CENTRE	14	
HUMAN RIGHTS TRIBUNAL OF ONTARIO	63	
LANDLORD AND TENANT BOARD	138	
LEGAL AID CLINICS	12	
LEGAL AID ONTARIO	150	
OFFICE OF THE INDEPENDENT POLICE REVIEW DIRECTOR	36	
OFFICE OF THE PUBLIC GUARDIAN AND TRUSTEE	180	
ONTARIO MUNICIPAL BOARD	14	
SOCIAL BENEFITS TRIBUNAL	39	
SPECIAL INVESTIGATIONS UNIT	13	
MINISTRY OF CHILDREN AND YOUTH SERVICES		155
MINISTRY-FUNDED SERVICE PROVIDER	13	
SPECIAL NEEDS PROGRAMS - CHILDREN	89	
YOUTH CUSTODY FACILITIES	19	
MINISTRY OF CITIZENSHIP AND IMMIGRATION		1
MINISTRY OF COMMUNITY AND SOCIAL SERVICES		2,301
DEVELOPMENTAL SERVICES PROGRAMS	501	
FAMILY RESPONSIBILITY OFFICE	1,157	
ONTARIO DISABILITY SUPPORT PROGRAM	621	
MINISTRY OF COMMUNITY SAFETY AND CORRECTIONAL SERVICES		4,211
CORRECTIONAL FACILITIES	3,839	
OFFICE OF THE CHIEF CORONER	25	
ONTARIO PAROLE BOARD	16	
ONTARIO PROVINCIAL POLICE	111	
OPP - CHIEF FIREARMS OFFICER	29	
PRIVATE SECURITY AND INVESTIGATIVE SERVICES BRANCH	10	
PROBATION AND PAROLE	53	
MINISTRY OF CONSUMER SERVICES		31
MINISTRY OF ECONOMIC DEVELOPMENT, TRADE AND EMPLOYMENT		5
MINISTRY OF EDUCATION		63
CHILD CARE QUALITY ASSURANCE AND LICENSING BRANCH	29	
MINISTRY OF ENERGY		7,060
HYDRO ONE	6,961	
ONTARIO ENERGY BOARD	51	
ONTARIO POWER AUTHORITY	19	
ONTARIO POWER GENERATION	14	
MINISTRY OF THE ENVIRONMENT		95
DRIVE CLEAN PROGRAM	20	

**Total figures are reported for each provincial government ministry including agencies and programs falling within its portfolio. Each government agency or program receiving 10 or more cases is also included.*

Appendix 1

COMPLAINT STATISTICS

TOTAL CASES RECEIVED 2013-2014
FOR PROVINCIAL GOVERNMENT MINISTRIES AND SELECTED PROGRAMS*

MINISTRY OF FINANCE		297
FINANCIAL SERVICES COMMISSION	45	
LIQUOR CONTROL BOARD OF ONTARIO	10	
MUNICIPAL PROPERTY ASSESSMENT CORPORATION	116	
ONTARIO LOTTERY AND GAMING CORPORATION	62	
MINISTRY OF GOVERNMENT SERVICES		257
REGISTRAR GENERAL	85	
SERVICEONTARIO	124	
MINISTRY OF HEALTH AND LONG-TERM CARE		597
ASSISTIVE DEVICES/HOME OXYGEN PROGRAMS	27	
COMMUNITY CARE ACCESS CENTRES	122	
HEALTH PROFESSIONS APPEAL AND REVIEW BOARD	18	
LOCAL HEALTH INTEGRATION NETWORKS	16	
MINISTRY-FUNDED SERVICE PROVIDER	45	
NIAGARA HEALTH SYSTEM	15	
ONTARIO HEALTH INSURANCE PLAN	149	
ONTARIO PUBLIC DRUG PROGRAMS	77	
PERFORMANCE IMPROVEMENT AND COMPLIANCE BRANCH	20	
MINISTRY OF INFRASTRUCTURE		1
MINISTRY OF LABOUR		752
EMPLOYMENT PRACTICES BRANCH	33	
OCCUPATIONAL HEALTH AND SAFETY BRANCH	18	
OFFICE OF THE WORKER ADVISER	15	
ONTARIO LABOUR RELATIONS BOARD	22	
WORKPLACE SAFETY AND INSURANCE APPEALS TRIBUNAL	95	
WORKPLACE SAFETY AND INSURANCE BOARD	552	
MINISTRY OF MUNICIPAL AFFAIRS AND HOUSING		25
MINISTRY OF NATURAL RESOURCES		58
LICENCES/TAGS	10	
MINISTRY OF NORTHERN DEVELOPMENT AND MINES		10
MINISTRY OF TOURISM, CULTURE AND SPORT		13
MINISTRY OF TRAINING, COLLEGES AND UNIVERSITIES		360
COLLEGES OF APPLIED ARTS AND TECHNOLOGY	100	
MINISTRY-FUNDED SERVICE PROVIDER	11	
ONTARIO COLLEGE OF TRADES	47	
ONTARIO STUDENT ASSISTANCE PROGRAM	134	
PRIVATE CAREER COLLEGES BRANCH	15	
SECOND CAREER	32	
MINISTRY OF TRANSPORTATION		525
DRIVER LICENSING - MEDICAL REVIEW SECTION	141	
DRIVER LICENSING	244	
METROLINX/GO TRANSIT	26	
VEHICLE LICENSING	66	

**Total figures are reported for each provincial government ministry including agencies and programs falling within its portfolio. Each government agency or program receiving 10 or more cases is also included.*

Appendix 2

HOW WE WORK

Appendix 3

ABOUT THE OFFICE

Early Resolutions: The Early Resolutions team operates as the Office's front line for receiving, triaging and assessing complaints, providing advice, guidance and referrals to complainants. Early Resolution Officers use a variety of conflict resolution techniques to resolve complaints that fall within the Ombudsman's jurisdiction.

Investigations: Complaints that cannot be easily resolved are referred to Investigations. The Investigations team conducts issue-driven, focused and timely investigations of individual complaints and systemic issues.

Special Ombudsman Response Team (SORT): The Special Ombudsman Response Team conducts extensive field investigations into complex, systemic, high-profile cases. SORT investigators work in collaboration with Early Resolutions, Investigations and Legal Services, and additional staff are assigned to SORT as needed.

Legal Services: Led by the Office's two Senior Counsel, the Legal Services team ensures that the Office functions within its legislated mandate and provides expert advice to the Ombudsman and staff in support of the resolution and investigation of complaints, the review and analysis of evidence and the preparation of reports and recommendations. It also co-ordinates the work of the **Open Meeting Law Enforcement Team (OMLET)**, which investigates complaints about closed municipal meetings (received pursuant to the *Municipal Act*) and engages in education and outreach with municipalities and the public with regard to open meetings.

Communications: In addition to co-ordinating the Ombudsman's reports, brochures, other publications and videos, the Communications team maintains the Ombudsman's website and social media presence, assists in outreach activities, and provides support to the Ombudsman and staff in media interviews, press conferences, speeches, presentations and public statements.

Corporate and Administrative Services: The Corporate and Administrative Services team supports the Office in the areas of finance, human resources, administration and information technology.

Appendix 4

FINANCIAL REPORT

During the fiscal year 2013-2014, the total operating expenditures for the Office were **$11.288 million**. Miscellaneous revenue returned to the government amounted to **$48,000**, resulting in net expenditures of **$11.240 million**. The largest categories of expenditures relate to salaries, wages and employee benefits at **$8.950 million**, which accounts for **79.3%** of the Office's annual operating expenditures.

SUMMARY OF EXPENDITURES 2013-2014

	(IN THOUSANDS)
Salaries and wages	$7,336
Employee benefits	$1,614
Transportation and communications	$355
Services	$1,383
Supplies and equipment	$600
Annual Operating Expenses	**$11,288**
Less: Miscellaneous revenue	$48
Net Expenditures	**$11,240**